THE STATE OF VA'S FISCAL YEAR 2015 BUDGET

HEARING

BEFORE THE

COMMITTEE ON VETERANS' AFFAIRS
U.S. HOUSE OF REPRESENTATIVES

ONE HUNDRED FOURTEENTH CONGRESS

FIRST SESSION

THURSDAY, JUNE 25, 2015

Serial No. 114–29

Printed for the use of the Committee on Veterans' Affairs

Available via the World Wide Web: http://www.fdsys.gov

U.S. GOVERNMENT PUBLISHING OFFICE
98–646 WASHINGTON : 2016

For sale by the Superintendent of Documents, U.S. Government Publishing Office
Internet: bookstore.gpo.gov Phone: toll free (866) 512–1800; DC area (202) 512–1800
Fax: (202) 512–2104 Mail: Stop IDCC, Washington, DC 20402–0001

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Thursday, June 25, 2015

U.S. HOUSE OF REPRESENTATIVES,
COMMITTEE ON VETERANS' AFFAIRS,
WASHINGTON, D.C.

The committee met, pursuant to notice, at 11:04 a.m., in Room 334, Cannon House Office Building, Hon. Jeff Miller [chairman of the committee] presiding.

Present: Representatives Miller, Lamborn, Bilirakis, Roe, Benishek, Huelskamp, Coffman, Wenstrup, Walorski, Abraham, Zeldin, Costello, Radewagen, Bost, Brown, Takano, Brownley, Titus, Ruiz, Kuster, O'Rourke, Rice, Walz, and McNerney.

OPENING STATEMENT OF CHAIRMAN JEFF MILLER

The CHAIRMAN. The committee will come to order. I want to thank everybody for coming today to talk about the state of VA's fiscal year 2015 budget. Members, I called this hearing two weeks ago following a series of concerning and inconsistent reports from veterans and Department of Veterans Affairs employees around the country about the current state of VA funding. I don't believe anybody was aware then of the troubling extent of VA's current budget crisis, except maybe those in the central office. And, unfortunately, I suspect that had I not called this hearing, we would still not be aware today of the $2.6 billion funding shortfall that the Veterans Health Administration is currently estimating, largely as a result of increased veteran demand for non-VA care and rising costs of hepatitis C treatments that VA did not properly plan for or manage.

Given the extensive pent-up demand for care that was exposed during last year's hearings on wait time manipulation, VA had ample time to adjust its budgetary needs with the Office of Management and Budget to prevent what we are now seeing today. February through April of this year, Secretary McDonald appeared at four separate budget hearings. Since those have concluded, the Secretary and I have met and spoken regularly on a number of important emerging issues. At no point in those discussions or hearings has the Secretary expressed to me that the Department had a budget shortfall of a magnitude of $2.6 billion, one that threatens VA's ability to meet its obligations to the veterans of this country, nor did other VA leaders or officials communicate how much in the red VA was either even though the committee was informed late last week that the Department knew as early as March that there

were giant disparities between the amount of money that VA was spending and the amount of money that had been budgeted.

The only message that Congress received in March regarding the state of VA's budget was the quarterly financial report that VA submitted to the Appropriations Committee for the first quarter of fiscal year 2015, which showed that VA was actually under plan in terms of its spend-out rate. Meanwhile, just 2 weeks ago, VA proposed a plan that Congress authorized at the Department's urging to transfer $150 million in fiscal year 2015 funding to support the continued construction of the replacement center in Aurora, Colorado. VA also proposed an across-the-board rescission of just under 1 percent in fiscal year 2016 funds to devote to the Aurora project, a proposal, by the way, that the Veterans Health Administration's chief financial officer told committee staff last week that she did not even know about until after it had already been transmitted to Congress.

I think these actions clearly show that VA leaders believe that moving forward with the Denver project, which is not scheduled to open to veteran patients until 2017 at the earliest, is a higher priority to the Department than ensuring that veterans who need care now are able to access that care. I have come to expect a startling lack of transparency and accountability from VA over the last years. But failing to inform Congress of a multibillion dollar funding deficit until this late in the fiscal year while continuing to advance what I believe are lower priority needs that further deplete the Department's coffers in support of a construction project that benefits no veteran for at least 2 more years is disturbing on an entirely different level.

Earlier this week, VA issued a fact sheet that claims that VA formally requested limited budget flexibility in February and in March and in May of this year and that plainly articulated VA's need for additional resources. Now, buried on page 167 of the second volume of VA's budget submission is a single statement that reads, and I quote: "In the coming months, the administration will submit legislation to reallocate a portion of Choice program funding to support essential investments in VA's system priorities," end quote. Secretary McDonald repeated this testimony without providing any additional supporting details or justification. And to date, there has been no legislative proposal that has been submitted by the administration to the Congress.

In May of 2012, a letter was sent to the chairmen and ranking members of the House and Senate Veterans Affairs Committees and Appropriation Committees regarding the Denver project. And VA stated that the Department, quote, "requests flexibility to make the Choice program work better for veterans through limited authority to use funds from section 802 of the Choice Act to fund care in the community to the extent it exceeds our fiscal year 2015 budget," end quote. Again, no further information or supporting materials have been provided.

If those two statements, absent of any other supporting evidence or details, are what VA calls "formally requesting budget flexibility and plainly articulating the Department's needs," then I understand why VA has, in fact, found themselves suffering nothing but string after string of failures since last year. Is more, it proves to

me once more, that VA's current problems reflect a management issue far more than they represent a money issue. This committee cannot help VA solve its problems if VA refuses to be honest, to be upfront, and to be transparent with us and with the American people about the position it is in, the struggles that it is facing, and the help that it needs.

Congress has consistently provided VA with the funding that the Department has requested. And as a result, VA funding has risen 73 percent since 2009 while the number of veterans using VA for care has grown by only about 2 percent. And this comes from VA's own testimony. I know that I speak for every member of this committee when I say that we are committed to ensuring that VA has the funding it needs to deliver the world-class healthcare our veterans deserve. But VA has got to do its part to confront and correct its poor budget planning and poor management issues, to hold poor-performing executives and employees accountable, and, perhaps most importantly, to prioritize our veterans' needs over the wants of a bureaucracy.

And if the current shortfall shows us anything, it is that what our veterans need and what they want is to have a say in when and where they get their healthcare. Assuming VA's numbers are true, non-VA care appointments now make up 20 percent of all of VA appointments, with veterans receiving more than 1 million appointments from community providers each month. In the coming weeks, I will work with my colleagues on the Appropriations Committee to try to give the VA flexibility it is seeking to use a limited amount of Choice funds for non-VA care and ensure that no veteran suffers as a result of VA's mismanagement of the generous budget the American taxpayers have provided. However, going forward, there has to be a dedicated appropriation account to fund non-VA care under a single streamlined integrated authority with a dedicated funding stream contained within VA's base budget, rather than the seven disparate, ill-executed, non-VA care programs that are outlined in VA's testimony.

This morning, I look forward to discussing the proposal with my friend, Deputy Secretary Sloan Gibson, and with committee members who all share the same concerns and want the same outcomes. I want to thank you all for coming back so quickly. I appreciate the ranking member being here today. And I will yield to Ms. Brown for her opening statement.

[THE PREPARED STATEMENT OF CHAIRMAN JEFF MILLER APPEARS IN THE APPENDIX]

OPENING STATEMENT OF RANKING MEMBER CORRINE BROWN

Ms. BROWN. Thank you, Mr. Chairman. Today's hearing is on the State of VA's Fiscal Year 2015 budget. I can tell you all that the state of VA's budget is not strong.

The VA is facing a shortfall of $2.6 billion for veterans' healthcare. This shortfall must be addressed immediately. We cannot put the health and lives of our veterans at risk by spending our time and attention pointing fingers and assigning blame.

The VA is facing shortfall at the start of the next fiscal year in October. A shortfall that will be made worse by the cost-saving

steps that VA is taking right now. We must address this upcoming shortfall.

I know that this Committee, as we have done so many times in the past, will work together to solve this crisis and fix this mess. I know that we all recognize that sometimes it takes new money to really fix a problem, and not just slapping some tape on it and calling it a day.

So in the words of Deputy Secretary Gibson, we will "get our checkbooks out." But I am concerned that there may be nothing left in the account as long as we continue to pretend that we can fund the essential requirements of government with our arbitrary budget caps. We seem to be heading, I am sorry, let me be clear, we are heading toward a government shutdown. Let me say that again: We are headed toward a government shutdown. I am concerned over the effects such a shutdown will have on veterans seeking healthcare.

Ten years ago, we addressed another VA shortfall. That shortfall was due to lack of sufficient planning and years of not providing the VA the resources that it needed. Today's shortfall also seemed to be caused by the lack of proper planning regarding the demand of veterans for VA healthcare. I am also concerned that inadequate planning leads to insufficient resources requests. We need to begin to fix these problems.

My bill, the Department of Veterans Affairs Budget Planning Reform Act of 2015, passed the House in March 420 to 0. It is a much needed reform in how the VA plans and budgets for the future. It is time that our colleagues in the Senate pass the bill and send it to the President.

If the VA is going to be there for our veterans, then we are going to have to fix the problems. This will call for more than us just opening our checkbooks or writing blank checks to the VA. It will require thoughtful and major reform so that we can ensure that in the years ahead the VA is worthy of our veterans.

But today, right now, we have veterans that need healthcare and checks we need to write to pay for that. And we need to make sure that these checks are not returned because we don't have sufficient funds in the account.

Then, and only then can we start the reform efforts so that VA is the model of how we care for those who have sacrificed for us and honored us with their service. Thank you.

And I yield back the balance of my time, Mr. Chairman.

[THE PREPARED STATEMENT OF RANKING MEMBER CORRINE BROWN APPEARS IN THE APPENDIX]

The CHAIRMAN. I thank the ranking member for her comments. And I associate myself with the vast majority of them, especially the one where we call on the Senate to please move and pass Ms. Brown's budgeting bill. I think we all agree that it is the appropriate thing to do. And at the same time, while I call on the Senate to do that, I hope Ms. Brown will join me on in calling on the Senate to pass the VA-MILCON appropriations bill over there that is so critical to funding for our veterans so they, can get the healthcare that they have earned. Thank you for your comments. Joining us on our first panel this morning is the Honorable Sloan Gibson, Deputy Secretary of the Department of Veterans Affairs.

Joining him today is Dr. James Tuchschmidt, the Interim Principal Deputy Under Secretary for Health; Edward Murray, the Acting Assistant Secretary for Management and Interim Chief Financial Officer; and Gregory Giddens, the Principal Executive Director of the Office of Acquisitions, Logistics, and Construction.

Thank you all for being here with us today.

Mr. GIBSON. you are now recognized for your opening statement.

STATEMENT OF THE HONORABLE SLOAN GIBSON, DEPUTY SECRETARY, U.S. DEPARTMENT OF VETERANS AFFAIRS; ACCOMPANIED BY JAMES TUCHSCHMIDT, M.D., INTERIM PRINCIPAL DEPUTY UNDER SECRETARY FOR HEALTH, VETERANS HEALTH ADMINISTRATION, U.S. DEPARTMENT OF VETERANS AFFAIRS; EDWARD MURRAY, ACTING ASSISTANT SECRETARY FOR MANAGEMENT AND INTERIM CHIEF FINANCIAL OFFICER, U.S. DEPARTMENT OF VETERANS AFFAIRS; AND GREGORY GIDDENS, PRINCIPAL EXECUTIVE DIRECTOR, OFFICE OF ACQUISITIONS, LOGISTICS, AND CONSTRUCTION, U.S. DEPARTMENT OF VETERANS AFFAIRS

STATEMENT OF HON. SLOAN GIBSON

Mr. GIBSON. One year ago today, 290,000 veterans were waiting more than 30 days for care. That number represented veterans needs we were unable to meet timely. For the past year, improving access to care has been among VA's top priorities. And we have made real progress: We completed 7 million more appointments for care inside VA and in the community than in the previous 12 months, double the additional capacity to required to meet those veterans' needs of a year ago; average wait time for completed appointments, 4 days for primary care, 5 days for specialty care, 3 days for mental health; scheduled appointments inside VA are up 12 percent; authorizations for VA care in the community are up 44 percent; 97 percent of appointments inside VA are completed within 30 days of the clinically indicated date or the date that the veteran requested.

We know that for many veterans, 30 days is far too long to wait. So we track shorter timeframes: 93 percent completed within 14 days; 88 percent completed within 7 days; and 22 percent of appointments completed on the same day. After hours and weekend appointments are up 12 percent. We have expanded the use of virtual care; secure messaging up 36 percent; mental health up 19 percent; e-consults up 36 percent; the NEAR list, the New Enrollee Appointment Request list, down 93 percent; the electronic wait list down 47 percent, all clear indications of improving access.

To achieve this, VA has been executing a strategy focused on building capacity through staffing, space, productivity and VA community care. Highlights: We have grown VHA staffing by 12,000 since April last year, including 1,000 physicians and 2,700 nurses. We activated 80 new VHA leases that add 1.3 million square feet to our healthcare footprint, plus another 400,000 square feet in VA-owned properties. Our relative value units, a standard measure of clinical output, have increased 10 percent, while our healthcare budget is up less than 3 percent. And 1.5 million veterans have

been authorized for care in the community, a 36-percent increase year over year.

Clearly, we are improving access, providing more care to more veterans. What is the challenge? As we improve access, even more veterans are coming to VA for their care. As a result, appointments pending over 30 days are now up 50 percent from where they were a year ago. Consider Phoenix, after adding 337 staff, completing 100,000 more appointments, and a 91-percent increase in care in the community, wait times are actually up. Why? In the same period of time, the number of veterans in Phoenix receiving primary care is up 11 percent, specialty care up 17 percent, and mental healthcare up 16 percent. We also saw it in Las Vegas, where we opened a new facility 2 years ago. Since then, the number of veterans receiving care there has jumped 18 percent.

Now, as we think about what is going on, let us not lose sight of the broader context. We are dealing with an aging veteran population. Over half of those veterans that are receiving care at VA are over 65. More veterans are filing disability claims for more conditions. The average degree of disability today is near 50 percent. Among veterans receiving disability, the average disability is 50 percent, meaning that many more veterans are eligible for healthcare in VA.

We also know that many veterans prefer VA healthcare. VFW's March survey of veterans reports that 47 percent of veterans who were offered Choice elected to wait to get their care inside VA; 78 percent said they were satisfied with their VA care experience; and 82 percent would recommend VA to a felony veteran.

One more thing that is very important for all of us to keep in mind, most veterans already have a choice: 81 percent have either Medicare, Medicaid, TRICARE, or some form of private insurance. Many come to VA because of the disparity in out-of-pocket costs between their insurance and VA care. For example, the average Medicare reimbursement for a knee replacement is about $25,000, with a copay of 20 percent. Choosing VA saves veterans $5,000.

So as VA improves access, which we are continuing to do, more veterans are going to come to VA because they either want to come or because they have a financial incentive to come. Now, as we look inside VA, what you are seeing here is evidence of is a sea change in the way we operate. Historically, as many of you heard me say, in the past, we managed to a budget number instead of managing to requirements based on veterans' needs. As we improve access to see veterans within 30 days, veteran response is placing extraordinary demands on resources.

Could we have managed this transition more effectively? I think we could have and should have. But, remember, we are running the largest healthcare organization in the country on a 20 year-old financial management system. We have had a hard time effectively factoring into our predictive analysis market penetration, changing veteran reliance on VA, and improving access and the impact that that has on veterans' choices. We didn't fully appreciate the challenge associated with changing internal VA processes quickly enough to accommodate the shift to Choice. We underestimated the time required for third-party administrators to build provider networks and the resistance that many providers would have to join

those networks. Notwithstanding our best efforts and much help from our VSO partners, many veterans still don't understand how Choice works. The limitations, particularly around geographic burden, which Congress has recently amended, made it impossible to use Choice in many instances and created additional demand for VA's traditional community care programs.

Lastly, veterans are demonstrating very clearly that their decision cycle timeline for care far outpaces the Federal budget cycle timeline. Likewise, medical breakthroughs don't follow the budget cycle timeline either. Hepatitis C treatment is an example of a new requirement impossible to forecast when our 2015 budget was first proposed. The first of the new generation of drugs to cure hepatitis C was approved by the FDA in early fiscal year 2014, over a year after we began the fiscal year 2014–2015 advanced appropriations budgeting process and less than a year before the fiscal year actually began. After adding these drugs to our formula in April of 2014, we soon realized we wouldn't have enough money to pay for them in 2015.

In September, we alerted Congress to the impending shortfall. Since then, the FDA has approved two more hep C drugs, all oral, no injections, fewer side effects, greater rate of cure, but expensive. To cure veterans of hep C in 2015, we moved $697 million from VA community care. But it wasn't enough. Veterans' desire for this treatment has been extraordinarily strong. And, simultaneously, we built capacity internally to meet veterans' needs quicker than we anticipated we would.

In May, to keep hep C veterans from needlessly waiting, we asked for some budget flexibility to use a limited amount of Choice program funding. Secretary McDonald raised the flexibility issue with this committee in February when he asked to use some Choice funding to meet the needs of veterans as they arose. Now, the Choice program is making a positive difference in the lives of veterans. And in every instance, if a veteran is eligible for Choice, we want to use Choice rather than any other community care option. I would point out that in February, approximately 5 percent of Choice-eligible care in the community was being authorized through Choice. By the time you get to the first week in May, that number was 10 percent. I now receive daily updates on our Choice penetration for Choice-eligible care. As of the 19 of June, we were up to 33 percent of the authorizations that were Choice-eligible. And I expect that number to continue to climb. But we still need flexibility in the use of Choice funds for the balance of 2015 and for 2016.

Further, we expect to need Congress' help as we consolidate community care channels as the chairman alluded to, including fewer program-by-program restrictions on those channels. Existing Choice Act funding can help meet these needs, needs more urgent now than when we first made the request in February.

But our investments have paid off. We are providing more care to more veterans. To keep progressing and providing veterans greater access to care today, we need the flexibility to use as much as $2.5 billion of Choice funds that were appropriated for veterans' care to pay for veterans' community care, exactly what Choice is for. And we already anticipate that we will rely heavily on Choice

in fiscal year 2016 to meet veterans' growing needs in that fiscally tight year.

For our part, our strategy will remain the same, leverage staffing space, productivity, and VA community care to its maximum capacity. We are going to do the right thing for veterans and be good stewards of taxpayer resources. And we are going to continue to work to make Choice a success. But to succeed, we need the flexibility to use funds to meet veterans as those needs arise. We look forward to working collaboratively with this committee and with Congress. And we look forward to your questions.

[THE PREPARED STATEMENT OF MR. SLOAN GIBSON APPEARS IN THE APPENDIX]

The CHAIRMAN. Can you tell us when you first became aware of the major budget shortfall, what is now becoming a multibillion dollar shortfall, at what point was that evident to you or the Secretary?

Mr. GIBSON. I actually brought with me in my folder a memo that I received from the VHA CFO dated 16 of March which indicated that, based on our financial system, we were still showing that we were underobligated. From that time forward, a process launched that covered several months during which millions of individual transactions in the fee-based care system were audited and reconciled in order to be able to determine the magnitude of the shortfall. It has only been within the last 3 or 4 weeks that we have been begun to get clarity around the magnitude of this disconnect.

Three issues here: One has to do with the push to accelerate access to care. One has to do with an antiquated financial system that doesn't have the automated interfaces that it needs with other systems like the fee-basis care system. And the third fundamental change that affected us this past year is the requirement in the Choice Act that we pull all of the budgeted funds for care in the community out of the medical centers and consolidate it in the chief business office. Those three factors together created this disconnect and the lack of clarity around what was actually going on in the fee-basis care area.

The CHAIRMAN. I was looking at a document that encapsulates the first quarter, which would have been the last quarter of last year, that was provided to the appropriators in March, of this year. And it is showing everything is on track at that point.

Mr. GIBSON. We were still showing everything was underobligated through February. And the questions that I kept asking were how can we be underobligated when we have got a 40-percent increase in authorizations for care in the community.

The CHAIRMAN. What was the response?

Mr. GIBSON. And that is what launched the review and reconcilement of the millions of transactions that were sitting out in the fee-basis care system to determine actually what had been obligated.

The CHAIRMAN. So you can see why the questions that are going to come from this committee today are absolutely——

Mr. GIBSON. Absolutely right. Inexcusable. But find a healthcare company out in the private sector of our order of magnitude that is operating under a 20-year-old financial management system, you are not going to find that.

So part of what we have to do is we have to find workarounds. We did what Congress asked us to do, pulled all the budget money in. What had historically happened was that care in the community against the budgeted funds got managed out in the medical centers. Well, care in the community decisions were still being made out in the medical centers, but all the budget dollars were sitting centrally. And so you had a fundamental disconnect between those two elements. Now, what we are going to have to do is build a workaround. Should we have built a workaround? Yes, we should have. Should we have asked Congress for relief from that requirement? Yes, we should have. We see that clearly with the benefit of hindsight.

The CHAIRMAN. Have you requested any specific legislation or changes at this point? Or is the central office still working on a detailed request? Because, again, as I stated in my opening statement, we have gotten very few statements that say VA would like to get more, money and would like to reform the Choice program. But I haven't seen any requests from VA yet.

Mr. GIBSON. We will, we have done briefings with staff. We will deliver very promptly a written request asking for flexibility in the utilization of Choice funds to pay for care in the community for veterans.

The CHAIRMAN. If we go down this path, and it is not a path that I want to go down, but it may be the only solution to a problem that has been coming for a considerable amount of time, reforms have got to be made and they have to be specific. We want to work with you as we go through that process.

Ms. Brown.

Mr. GIBSON. Thank you. Thank you. And we appreciate that.

Ms. BROWN. Thank you. I am going to ask a question because I want something cleared up. Explain the difference to us between the fee-based and the Choice.

Mr. GIBSON. The fee-basis care system is a system that we use to track individual authorizations for care. And that is where we ultimately wind up reconciling all the way back to an in invoice and ensuring that we receive the clinical information from the individual veteran's care. Unless I am mistaken, I think fee-basis care system also captures Choice authorizations——

Ms. BROWN. We need to be clear what is fee-based. I cannot go to a doctor before we passed Choice in the community.

Mr. GIBSON. That is, there is an authorization process that veterans would pursue, either working directly through their medical center when they are calling to ask to schedule an appointment, and if we can't schedule it timely, they get referred to the third-party administrator to schedule an appointment in the community. Or, alternatively, if they are 40 miles from their facility, then they would just call the third-party administrator directly to get that appointment for care scheduled.

Ms. BROWN. And Choice.

Mr. GIBSON. That is Choice. That is Choice. And other, there are six or seven—it is in the written testimony—six or seven different programs. The chairman alluded to this, and I completely and totally agree, we have got do reconcile the six or seven different programs that we utilize for Choice in the community. It confuses vet-

erans. It confuses our staff. It is confusing to providers, different payment reimbursement rates, different payment mechanisms, different requirements for authorization, different processes. It is thoroughly confusing.

Ms. BROWN. I understand that it is. But are the veterans getting the care in the community?

Mr. GIBSON. We are estimating right now that in fiscal year 2014, we will see somewhere in the neighborhood of between 21 million and 23 million appointments for care in the community. That is up from about 16.5 million in 2014. And, as I mentioned, there are a record number of veterans who are receiving authorizations for care in the community, 1.5 million over the last 12 months, a 36-percent increase over the prior period.

Ms. BROWN. Is any of that in the mental health area?

Mr. GIBSON. Yes, ma'am. It is.

Ms. BROWN. What percentage?

Mr. GIBSON. Mental health for us historically has been a relatively smaller percentage of care referred into the community because oftentimes veterans experience issues that VA providers are potentially better positioned and more knowledgeable to be able to respond to. There is certainly mental healthcare out there. But the vast majority of that care is delivered inside VA.

Ms. BROWN. Okay.

I am going to yield back my time. And I hope we are going to have a second round.

The CHAIRMAN. I think we will have an opportunity to do that.

One question real quick, Mr. Secretary.

Mr. GIBSON. Yes, sir.

The CHAIRMAN. Over the past months, we have examined improper procurement practices, failures to pay providers in a timely fashion, gross mismanagement of construction projects. We all know about Aurora. And I am going to be yielding to the gentleman from Colorado in a second. These are all big news stories. But this committee has also heard many instances of simple, smaller waste, fraud, and abuse by poor management and bureaucratic inertia that appears to be the culture within the system. I know you are trying to root it out. But one in my State—in particular, is the Augustine and the CBOC that is there right now. How can VA continue to justify paying thousands and thousands of dollars in fines and penalties each month to retain a CBOC in a facility when they knew a long time ago that they were going to have to relocate from that facility? How does that happen?

Mr. GIBSON. It happens when we fail to forecast far enough in advance the need to relocate from an expiring leased facility. And what happens is we wait too long. And then we start working to define requirements and run through all the process. And we find, for instance, here, I think there were issues associated with site selection that delayed it. And we wound up in the situation precisely that you are describing.

We have got—I don't know how many—hundreds of lease transactions in the pipeline right now. That has become a major part of our business. We have under allocated resources to that part of our business. And we have got to better manage it, as well as streamlining the processes, as well as developing more standardization in

lease design so that we can work through these, through the process and the design more expeditiously.

The CHAIRMAN. Ms. Brown, since it is your part of the State.

Ms. BROWN. It is my part of the State. And, in addition, we had a briefing on that when you, and I were in Orlando. And it is not as simple, it is more complicated in that the city and the county and how we can, and this is something we need to address, that if a city wants to give us some property to relocate, we can't just take it. That is something that we need to address.

Mr. GIBSON. Yes, ma'am.

Ms. BROWN. All apples are not the same.

Mr. GIBSON. But the chairman's point is an accurate point. And St. Augustine is just one examine. In fact, this happens all too often, where we have not made plans far enough in advance to be able to run through all the process—and it is a long process—to get to the point where we have actually got, we are ready to replace the facility before the lease actually expires.

Ms. BROWN. And this not only happened in St. Augustine. It happened in Tallahassee also. So this is something that we, as a committee, need to address.

Mr. GIBSON. Yes, ma'am.

Ms. BROWN. And change the process.

Mr. GIBSON. We are working it. And that is the guy right there that is principally responsible for fixing it.

The CHAIRMAN. I saw him point at you, Mr. Giddens.

Mr. GIDDENS. Sir, yes, sir.

Mr. GIBSON. I point at him quite often these days. We are going to talk about supply chain at some point. I am going to point at him again.

The CHAIRMAN. Thank you very much.

St. Augustine is very important not only to the veterans that are in that area but also to trying to change this culture that has been allowed to go on for too long.

Mr. LAMBORN. you are recognized.

Mr. LAMBORN. Thank you, Mr. Chairman. I want to thank you and the ranking member for your leadership.

Secretary Gibson, although I am glad to see in your written statement that the VA is, quote, "committed to doing what is right for the veterans in the Colorado region and completing this major construction project without further delay," unquote, I am still deeply disturbed and disappointed by the additional time and money that it is going to take. Thanks to recent legislation and a reallocation of funds, we are now good through the end of the fiscal year, but much more remains to be funded. This is a critical facility that our Colorado veterans have earned and need. And I remain committed, along with my colleague, Representative Coffman, and others to ensure that we bring this project to completion.

However, as we are sitting here talking budget shortfalls and mismanagement. I have to ask, where is the accountability? When we have poor management, whether it is forecasting the budget, or whether it is poor construction projects, where is the accountability? We have given you additional legislative authorization, you and the Secretary. And we really don't see that being used. Where is the accounted ability, Mr. Gibson?

Mr. GIBSON. If you look back, as I have, at the entire chain of command, from the Secretary all the way down to the project engineer, I believe there is only one person that was substantively involved in the project who still remains at VA. And I think that is the project—not project engineer but project executive. There has been an AIB that is in the process of wrapping up. I think we have talked earlier in this committee about early evidence that was gathered by that AIB, which was being used to prepare charges against a senior executive who then retired in the face of that impending personnel action.

A similar process happened recently with the senior attorney that was involved very heavily in Denver. And I expect the AIB to wrap up very quickly. And we will consider the evidence raised by the AIB for any additional individuals that are still on the payroll in the Department.

Mr. LAMBORN. Okay. Thank you.

And also, Secretary Gibson, you have asked for additional flexibility in allocating your funds but haven't provided what I believe is the supporting data needed for that. More importantly, I want to ensure that there isn't the impression that the VA has decided to fund the Denver Hospital project ahead of hepatitis C treatment or any other veteran medical care. That won't be the case, will it? And can you clarify?

Mr. GIBSON. Certainly, there is not any intention to trade off hep C care for Denver. We have gone through a whole series of proposals on Denver, starting with what I continue to believe was the best proposal for veterans and for taxpayers, which was to utilize construction funds, nonrecurring maintenance and minor construction, that were provided as part of the $5 billion under Choice. That got nowhere. There were other alternatives considered where we would reprogram dollars from major construction projects, projects that aren't due to start construction for 3 years or 4 years. That got nowhere.

We have looked at alternatives to reduce, to move proposed funds in 2016 from nonrecurring maintenance and minor construction. That got nowhere. So what we have finally gotten to is the tactic of an across-the-board cut with an intention that VA would have the time over the course of the year to be able to manage those reductions on a very micro level so that we ensure that we are not adversely impacting veteran care.

Mr. LAMBORN. Well, I want to speak for myself and I am sure every member of the committee would agree, we can't do any fix that in any way compromises veterans' healthcare. Thanks for being here.

Mr. Chairman, I yield back.

The CHAIRMAN. Mr. Takano, you are recognized.

Mr. TAKANO. Thank you, Mr. Chairman.

And thank you, Secretary Gibson, for your acknowledgment that things could have been better planned out. And there could have been better management. When you talk about this financial management system, are you talking mainly about administration or outdated software? What is it you are referring to?

Mr. GIBSON. We have, like companies in the private sector, we have a major technology system, IT system, software system, that

we use to account for all of the financial activity of the Department. I recently interviewed a candidate to come in and head IT who was astounded to learn that we were still using it because he had helped develop it back when he was a beginning software engineer 30 years ago.

Mr. TAKANO. We are talking about IT?

Mr. GIBSON. Yes, we are.

Mr. TAKANO. And I know that there is problems engaging non-VA providers. The VA has the obligation to manage accountability with those providers. And there is a lack of ability to use electronic medical records with the system. So we definitely need to look at investing and upgrading that system. I understand a large part of the shortfall comes from increased payments for fee-based care or contracts with non-VA providers. When you say "community care in the community," you mean non-VA providers, right?

Mr. GIBSON. That is exactly what I mean.

Mr. TAKANO. Do you have an estimate for how much of that care could have been provided through the Choice program but wasn't? In other words, how many of those veterans would have qualified for Choice but received care by another means because of the slow rollout of the Choice program? If you don't have that number, you can get it to me later.

Mr. GIBSON. Let me take that for follow up. But I will tell you it is not 100 percent because we can't use Choice dollars for long-term care. We can't effectively use it for dentistry because you can't find many Medicare-approved dentists out there. We can't use it for obstetrics because, as you might expect, there aren't many obstetricians who are Medicare providers. But it is a very substantial amount that could have been channeled to Choice.

Mr. TAKANO. So a big chunk of this money we are talking about——

Mr. GIBSON. Yes.

Mr. TAKANO [continuing]. Could have been used for Choice?

Mr. GIBSON. Yes.

Mr. TAKANO. Could have qualified them?

Mr. GIBSON. Yes.

Mr. TAKANO. And you are saying that there is all those different reimbursement rates out there for the different kinds of non-VA care. My next question was of the remainder of the folks that would not have qualified, how much of that, could you quantify that in terms of how much of that was attributable to a lack of capacity at the VA, that were not fully staffed up at the VA? If you were fully staffed up, could we have taken care of more people who would not have qualified for the Choice Act?

Mr. GIBSON. I think the short answer is yes. If we were fully staffed up, if we had all the facilities we needed, yes, we could have. But there are instances, for example, we have relied and come to rely heavily, for example, on state nursing homes to care for veterans. And so that winds up being I am going to say $1.5 billion, round numbers.

Ed, is that in the neighborhood?

Mr. MURRAY. It is close. It is $1.1 billion.

Mr. GIBSON. And so that is a substantial portion of that that we have come to rely on outside providers for that.

Mr. TAKANO. I want to turn to hepatitis C for a moment. I am very concerned to hear about the lack of funds to continue to provide treatment for veterans with hepatitis C. It is estimated that more than 184,000 veterans are infected with hepatitis C. And these men and women served their country and should not be denied access to a cure. And I commend the work that the VA has done to build capacity to treat veterans with hep C. And we can't lose ground. The new treatments for hep C can be extremely expensive. It can cost as much as $1,000 a pill commercially. Fortunately, I understand the VA has been able to negotiate with the drug companies to a lower cost. I have heard estimates that VA is, instead, paying closer to $600 a pill, is that correct? You may not have an——

Mr. GIBSON. I would like to not have to answer that question. We work very closely and collaboratively with the manufacturers of those drugs and have been able to reach attractive arrangements for the continued purchase of those drugs. And we continue to have those conversations.

Mr. TAKANO. What I am curious about is if maybe our veterans are maybe choosing to go to VA as opposed to the private care or TRICARE or other options because they might get access to this medication more easily, and the doctors might be able to get the treatment done in a more timely manner.

Mr. GIBSON. I think that is certainly the case. If a veteran who is Medicare-eligible was to go to a private provider, he would wind up with a very substantial copay that he would have to pay in order to be able to receive that care.

Mr. TAKANO. Thank you.

The CHAIRMAN. Thank you very much, Mr. Takano.

For the record, this Congress has provided hundreds of millions of dollars in the past few years, in fact, one particular system was called Core FLS. This money was squandered. And we actually have nothing to show for it. I think that additional investments are going to have to be made to be brought up to par.

Mr. TAKANO. Can you explain more to me about the Core FLS?

The CHAIRMAN. It was a financial system.

Mr. TAKANO. Oh, you are talking about the IT?

The CHAIRMAN. Yes. I agree with what you are saying. I am just saying there have been, again, hundreds of millions of dollars spent in error somewhere, never been used.

Mr. TAKANO. I appreciate that. And my sense, since I have been here, that the rollout, I kind of had this feeling that if they didn't have this ability to have electronic medical records and doing it all by paper and photocopying things, that they were going to have a hard time engaging non-VA providers then. That is my point.

The CHAIRMAN. And an excellent point. Thank you very much.

Mr. BILIRAKIS. You are recognized.

Mr. BILIRAKIS. Thank you, Mr. Chairman. I appreciate very much.

And thank you, Mr. Secretary, for your testimony. The VA has estimated a $2.6 billion shortfall for the remainder of the year, which will impact the delivery of care to veterans and may affect the following year's budget. How accurate, how firm are you on that $2.6 billion?

Mr. GIBSON. I think it is a very, at this point in the fiscal year, we are just slightly over 3 months away, I would say it is a very accurate forecast. It does, it does assume business as usual.

Mr. BILIRAKIS. How do you come to that conclusion?

Mr. GIBSON. Well, this was built, as I alluded to earlier, we have had people go back and look and do reconcilements, millions of transaction reconcilements in the fee-basis care system looking at past patterns of authorization and numbers of appointments per and the cost of each of those appointments, looking at the month-by-month track record and the numbers of authorizations, so it is really a forecast that is built from the bottom up.

Mr. BILIRAKIS. Okay. Considering VA's inability to adequately plan to implement programs and construction projects resulting in cost overruns, such as the Denver project, how much of the shortfall in your estimation would you say was due to mismanagement of funds as opposed to the level of funding appropriated by Congress? Because, again, since 2009, we are up 40 percent. Do you agree with that? How much is due to mismanagement?

Mr. GIBSON. I don't think any of it is due to mismanagement. Should we have done a better job of managing the buckets of different money that had been appropriated? Absolutely, the answer is yes. But what we have basically done here is pushed to accelerate access to care. This issue, what has happened is we have, back to my point earlier, a 36-percent increase in the number of veterans that have been authorized for care in the community.

Mr. BILIRAKIS. None of it is due to mismanagement?

Mr. GIBSON. This is about providing more care to more veterans. That is what this is about.

Mr. BILIRAKIS. How much has the VA spent in performance, retention, and relocation bonuses for fiscal year 2015?

Mr. GIBSON. I will have to take that for the record. I don't know the answer.

Mr. BILIRAKIS. Can anyone on the panel, can they answer that question?

Mr. GIBSON. I think most of the performance awards are paid at the end of a fiscal year. But there are some that are paid on an ongoing cases to physicians, as I understand it. I will get you a number.

Mr. BILIRAKIS. Can you get that information to me?

Mr. GIBSON. Sure. Yes, sir.

Mr. BILIRAKIS. I appreciate that very much. Can't some of these unobligated funds in those accounts be reprogrammed for, to address a portion of the budget shortfall? Again, do you need specific authority from Congress to do that, to reprogram some of these funds?

Mr. GIBSON. I would not expect that we would need authority from Congress to reprogram some of those funds. And as we work——

Mr. BILIRAKIS. Is that your intention to reprogram some of those funds?

Mr. GIBSON. We are looking everywhere we can look to identify funds to be able to support care for veterans in the community.

Mr. BILIRAKIS. Thank you.

I yield back, Mr. Chairman.

The CHAIRMAN. Ms. Brownley.

Ms. BROWNEY. Thank you, Mr. Chairman.

I was back in my district last week and had a meeting with our veterans and TriWest came out and we talked a lot about the Choice program and provided more information and education to our veterans there.

And I also had a meeting with the VISN network director in my district as well. And she provided me with some information. I am hearing from my veterans, I heard from her as well, that a group, private group called the Oxnard Family Circle, that provides adult day services in my district, they happen to be right next door to our CBOC. So there is a certain synergy there between the CBOC and the adult day center for our veterans. And we have been told now, because of lack of funds from the VA, that the Oxnard Family Circle is not going to be receiving any more funds. And we now have a queue of 15 veterans who are waiting to get into that facility. And the VA has said: Sorry, we are not going to be able to accommodate that. Maybe on a case-by-case basis, given extenuating circumstances, we might be able to accommodate a few.

That is a certain for me because I am beginning to already, at least in my district, feel the implications of the dilemma that you are presenting here. And I am concerned that that is going to, you know, bleed into other areas, in-home healthcare services, other kinds of things. At the same time, we have providers in the district, mental health providers that VA has contracted with, and yet we are not utilizing them to the extent that they can be utilized. And we are not pushing our veterans to those contracts.

And, thirdly, I would say that TriWest I think is very committed to administering the Choice program. They have indicated that they plan on hiring lots and lots of folks to do a better job of providing the Choice program. So all of these issues that I am raising right now are sort of fighting against each other. We are going to need resources for the Choice program in order to increase and enhance the program. And we wouldn't want TriWest to hire a lot of people and then tell them: Sorry, we have got to push more people to the people that we have already contracted with.

And yet my veterans in Ventura County are not receiving the services and are beginning to feel this dilemma. So I am not sure that I have a question. I am not sure I have a question except to say I thank you for your leadership. I do believe that if you weren't asking the hard questions, your issue around financial, the financial management system and continuing to ask those hard questions, you and the Secretary both, that we still might not be aware of this problem surfacing the way it is surfacing. So I appreciate that.

I don't think we can look back in terms of our past mistakes. We have got to look forward. And so I do believe that we need the flexibility because the money really needs to follow the veteran in terms of what he or she selects in terms of their service. So, again, I am just very, very concerned about what is happening in my district to my veterans as we speak and wondering if there is any remedy to that.

Mr. GIBSON. Well, we are concerned as well. Two of the categories that you mentioned, adult daycare and home-based care,

are two services that we are not able to use Choice to be able to fund. That would be part of the flexibility that we would really love to be able to have because we don't want to see that care disrupted. We will do some homework on the mental health providers and look into that. The other point that I would make is, I mentioned earlier that across VHA, we are up to about 33 percent of all authorizations for care in the community are going to Choice. And TriWest territory, they are up to 41 percent. And I think it is because of that determined effort that they are making out on the ground day in and day out to see that we are using Choice in every case we possibly can.

Dr. TUCHSCHMIDT. If I could just add on about the mental health providers, we do have relationships, long-standing relationships with 87,000 providers around the country. And we are doing everything in our power to reach out to those folks. We have sent them a letter. We have asked local leadership to meet with those providers, encouraging them to sign up and become Choice providers. So we want the patients that—the providers that our patients have been seeing to continue to be able to see those people under the Choice program.

Ms. BROWNEY. Thank you.

And I yield back, Mr. Chairman.

The CHAIRMAN. Ms. Brown.

Ms. BROWN. On that, I had a similar situation. And I brought in the HUD vouchers, and we were able to get 30 of our veterans signed up because they had no income and now they will have that income. So that is something that we need to keep in mind because these agencies need to work together.

Ms. BROWNEY. Thank you.

Ms. BROWN. I yield back.

The CHAIRMAN. Dr. Benishek.

Dr. BENISHEK. Thank you, Mr. Chairman.

Thanks for your testimony, Mr. Gibson. Frankly, I am a little bit shocked by the fact that you sit there and tell me there has been no mismanagement, and we have got $1 billion cost overrun on the hospital in Denver. That can't be, if it is not mismanagement, then it is just the standard way of doing things at the VA.

And, frankly, I was really hoping that the new Secretary would be able to revamp the VA because I think that business as usual has not been working very well for the last 30 years and that the layers of the bureaucracy, where there is so many layers of the bureaucracy at the VA as compared to, say, a private sector corporation of a similar size would be much more streamlined. And I was hoping to see a dramatic change in the organization of the VA so that things would be much leaner and meaner and that 20 year-old IT systems wouldn't be used as an excuse to explain why we are hearing at a late date there is a $2.7 billion cost overrun.

So, you know, I still have a level of hope that something like that is still in the offing. Is anything like that in the offing, a complete revamping of the bureaucracy of the VA? Or is it going to continue the way it is? I am just not happy with the progress that we are seeing today, another instance of a surprise cost overrun, not being able to figure out that hepatitis C is going to cost us money, and all of the things that you mentioned.

Mr. GIBSON. Yes, sir. First of all, to be very clear, there was gross mismanagement in Denver. The question, as I heard it, that I was being asked had to do with the $2.5 billion——

Dr. BENISHEK. That is part of the whole deal, right? There is $2.5 billion missing and——

Mr. GIBSON. It is not missing. No, sir, it is not missing. It is money that is going to pay for veteran care in the community. That is what we are talking about.

Dr. BENISHEK. I understand that. But it is a cost overrun that somehow money in your Department has been spent on all kinds of stuff. We don't know what most of it is because it all disappears. IT, we spent hundreds of millions of dollars, it hasn't been updated. It just disappears within your system. That is what I mean about having more control over what is happening with the money.

Mr. GIBSON. We would love to come brief you on My VA, which is the long-term plan for the transformation of the Department. We would relish the opportunity to do that, the organizational changes, the culture changes, the training, the staffing.

Dr. BENISHEK. I would like to see something dramatic done to change the status of the VA so that it is much better than this bureaucracy that we have here now and that we are hearing another example of. I want to go——

Mr. GIBSON. Well, I would just, I would just mention, you alluded to the fact that it has been going on for 30 years. Secretary McDonald has had 10 months. So that doesn't mean that we don't need to be getting things done. We do. But I think we have to take into account the fact that changing an organization as large as VA in less than a year, I am not sure who would be able to do that, inside the Federal Government no less.

Mr. BENISHEK. I have another question about this fee—or, not actually the fee basis—the Choice Act, okay, and, you know, the slow implementation of the Choice Act. And I think part of it is the problem with, you know, getting a provider list up there.

And it is my understanding that, you know, we were going to be paying Medicare rates for care. But it is also my understanding that, you know, the third-party providers are getting Medicare rates, but the actual people that are doing the care are not getting Medicare rates. They are getting a less-than-Medicare rate. And some of the provider people that I have talked to said that the rates are 30 percent less than Medicare rates. So they are reluctant to sign up for it because, you know, they are losing money.

Mr. GIBSON. That is the issue that I alluded to in my opening statement about providers' reluctance to sign on to Choice.

There is a widely held misperception, and I think a lot of it has to do with the fact that we wound up having to use the two third-party administrators for Choice off of the PC3 contract, where it is below Medicare. And so providers out there associate Health Net and TriWest signing them up with PC3 below Medicare rates, but, in fact, what we pay in Choice is Medicare. That is what we are paying.

And I have personally had conversations with providers and academic affiliates where they go, "Oh, well, we didn't know that."

Mr. BENISHEK. Well, that is not the information that I have had, okay? Because the people that I have talked to, hospital adminis-

trators for example, have told me that, well, we had a better deal before when we were doing the fee-for-service stuff or we had a contract with the VA. And then they don't want to sign up——

Mr. GIBSON. They probably had a better deal before when they were doing a one-off contract with VA. But I doubt seriously that they had—I know they would not have had a better deal under PC3.

We would be glad to share with you the letter that has gone to providers, which makes it explicit, very clear in the letter——

Mr. BENISHEK. I would like to see that, then, because that runs contrary to the information that I have received anecdotally from individuals.

Mr. GIBSON. And——

Mr. BENISHEK. I will yield back my time.

Sorry.

The CHAIRMAN. Ms. Titus, you are recognized.

Ms. TITUS. Thank you, Mr. Chairman.

Thank you, Mr. Gibson, for being here. You are always amazingly patient, coolheaded, and straightforward, and I appreciate that.

I know that the VA has just been overwhelmed by dealing with problems of the past, but it seems to me that a real problem, in addition to an old IT system or an old financial system, is a lack of a planning system.

You know, we didn't have the planning for the cost of treating the hepatitis, and yet medical technology is changing so rapidly, and new medicine is being developed. And we didn't really plan for this backlog that is developing now with the appeals process, which is a result of resolving the backlog with the original filing.

And, as you mentioned, we don't have a very good way to plan for demographic and geographic shifts. I have been saying since the first day that I worry about places like Las Vegas, where the demand is increasing. The New York Times said it was a 20-percent increase in Las Vegas. You said in your opening statement that it is 18 percent, but, you know, give or take a few.

We are going through money quicker. Our VISN is burning through the RVUs. Will we run out of the money sooner? If that happens, what will I say to veterans in Las Vegas? How did you make up for that kind of money?

And is there anything in the works to look at the whole planning process?

Mr. GIBSON. That is a great question and a great issue.

The staff brought me my briefing deck to give 2017 budget guidance to the organization. And when I got to the recommendation page, my choices were to nudge number up a little bit, nudge another number down a little bit. And I said, wait a minute, that is not the way we are going to do this. We are going to build a requirements-based budget, and the requirements starts with what we expect to deliver to the veteran, the veteran's experience.

So I am going to take appeals as an example. You mentioned it. Let's say, hypothetically, we want to give a veteran an appeal decision within a year of the filing of their notice of disagreement. Right now, it is more like 4 years, 5 years, something like that. We obviously can't meet that standard immediately. We decide how

long it is going to take to meet that standard. And then the conversation that we wind up having is about the requirement and the resources needed to meet that requirement.

Same conversation on hep C. The last time I was here in this committee, I proposed the idea that, let's take hep C prevalence among veterans that are getting care at VA to functional zero within 3 years. Let's let that be the requirement that we manage to. We all agree to that, and we all understand what it would cost to do that, and then VA executes to that requirement.

That is how you build a plan that starts with the veteran experience that you are trying to deliver. You are absolutely right.

Ms. TITUS. I hope so.

And just for the record, I agreed to go along with the bridge money for the Aurora hospital that gets us to the end of the fiscal year. It was a patch, a little here, a little there, you took from other projects around the country.

But I cannot vote for a 1-percent across-the-board cut. I think that is a bad way to do budgeting. I have always voted against amendments that just do across-the-board cuts. I think you have to look at where you need the money and where you don't, not just slice it across.

So I hope you will come with another proposal, because, when the time comes, I cannot cut other veterans benefits across the board to bail out a bad construction project in Denver.

Thank you. I will yield back.

The CHAIRMAN. Mr. Huelskamp, you are recognized.

Dr. HUELSKAMP. Thank you, Mr. Chairman.

Mr. Secretary, I want to follow up on a few things that have been discussed here. I think the opening questions from the chairman of the committee was about when did you know, and I didn't ever quite hear exactly the answer of when you were actually informed about an approximately 40-percent cost overrun in this budgetary fund.

Mr. GIBSON. It became clear that there was a very large variance, I would say, in mid- to late May, in that general timeframe.

Dr. HUELSKAMP. Okay.

Mr. GIBSON. Mid-May probably. And we began working with OMB, looking at a whole series of alternatives and different possible solutions within funds that we may or may not have had direct control over.

Dr. HUELSKAMP. My second question would be—and I appreciate that—where are we at today on the Choice fund? How much have you used? I know the President had submitted a budget, and there was some strong pushback about raiding the Choice funds. Can you tell me where we are at on those funds?

Mr. GIBSON. I think, under 802, it is a little over a billion dollars. Is that right? I can't read that without my glasses.

Mr. MURRAY. 437——

Mr. GIBSON. For care.

Mr. MURRAY [continuing]. For care. And $402 million under the 801 section. So it is 940 total.

Mr. GIBSON. So $940 million. I was close. I was estimating about——

Dr. HUELSKAMP. So is it used or underused or overused? Which is the——

Mr. GIBSON. Well, I would tell you that back when we did our first estimates on Choice we were looking at utilization somewhere on the order of $3 billion in the first year. So it is interesting to us, as we step back and we look at what we have done in accelerating care in the community and looking at what we had originally forecasted for Choice utilization——

Dr. HUELSKAMP. But compared to February, though, when you came in and proposed that you raid the Choice fund and use it for other funds—which sounds like what you are talking about doing here today. Is it where you predicted it was in February when the President proposed to raid the Choice fund?

Mr. GIBSON. I am sorry. I don't understand the question.

Dr. HUELSKAMP. In the President's budget, he had proposed to raid the Choice fund and use it elsewhere, including non-VA care, if I understood his proposal.

Mr. GIBSON. Correct.

Dr. HUELSKAMP. You are here today to say, well, we ran short, even though we really didn't know about it till May, even though the President proposed to do that for 2016 in his February budget proposal. My question is——

Mr. GIBSON. I think there was——

Mr. HUELSKAMP [continuing]. Where are you at today, really, on Choice funds? You said $940 million. What did you project you were going to spend?

Mr. GIBSON. Between now and the end of the year?

Dr. HUELSKAMP. Yes.

Mr. GIBSON. I would say we will be—an optimistic spend is a total of a billion and a half dollars, an additional $500 million worth of care. And if we are able to spend that $500 million for care inside Choice, that reduces the two-and-a-half-billion-dollar shortfall.

Dr. HUELSKAMP. And following up on when you knew about the shortfall and when you told Congress, what is typical practice? You wait till the end of the fiscal year and add up all the bills and see where you are at?

It sounded like you did something out of the ordinary to say, hey, let's see where we are at, because it looks like, eyeballing it, we are 40 percent over. Is that normally—well, how often do you figure out where you are at on the budget?

Mr. GIBSON. We are looking inside the financial management system, as was mentioned earlier, and providing reports to appropriators at least on a monthly——

Dr. HUELSKAMP. Well, how often?

Mr. GIBSON. At least on a——

Dr. HUELSKAMP. You find out in May you are 40 percent over——

Mr. GIBSON. At least on a monthly basis. The point that I made earlier is, as of the middle of March, March the 16th, I have a memo that says through the first 5 months of the year we are under-obligating. And it didn't make sense. And that is why we had people go back and do manual reconcilements literally of millions of transactions inside the fee-basis care system to figure out

exactly what had been obligated, because we don't have the automated interfaces between——

Dr. HUELSKAMP. I still don't understand what happened in the—so the March memo you are talking about, was the data falsified? Inaccurate? Are they——

Mr. GIBSON. The data was—they were reporting what was in the financial management system. And what was in the financial management system didn't take into account all of the specific details of every single individual authorization for care.

Dr. HUELSKAMP. And that is business as usual. They give you reports, even though they know——

Mr. GIBSON. No. In fact, historically, a lot of this reconcilement would have been done at the medical-center level, where we used to keep the budget. But when Congress passed the Choice Act, they required us to take all the money out of the medical centers and consolidate it into the Chief Business Office. So we were faced with——

Dr. HUELSKAMP. And you knew that in March. You knew that in March.

Mr. GIBSON. We knew it in September.

Dr. HUELSKAMP. That was not a change in March. That was a change last summer.

Mr. GIBSON. We knew it when Choice passed.

Dr. HUELSKAMP. And so I am still trying to figure out how you can have a 40-percent cost overrun in this budget, come to Congress in June and say, oh, by the way, we have a couple months left, and, oh, by the way, don't forget we asked to raid Choice in February.

And I am concerned about that. I am concerned about the implementation of Choice and——

Mr. GIBSON. I think that the allusion in the budget document was an allusion to—and the Secretary has said this repeatedly—give us the flexibility to be able to use money to follow the veterans.

And that was my comment about veterans make decisions faster than the budget cycle. And, quite frankly, we can't change as fast as we need to change to accommodate the needs of——

Dr. HUELSKAMP. And, lastly, a little bit more. If I understand you correctly, you mentioned about 12,000 individuals you hired?

Mr. GIBSON. Net increase. That is net.

Dr. HUELSKAMP. How many of those were direct care providers?

Mr. GIBSON. More than 1,000 are physicians. More than 2,700 are nurses. I can't tell you how many were psychiatrists, psychologists, but——

Dr. HUELSKAMP. Well, I would like to know that, because——

Mr. GIBSON. Okay.

Dr. HUELSKAMP [continuing]. Based on the figures you gave us, only a third of what you hired was for direct care——

Mr. GIBSON. We can certainly do that.

Dr. HUELSKAMP [continuing]. Two-thirds for something else.

Mr. GIBSON. One of the biggest challenges we have throughout VA is we don't leverage our providers with sufficient support staff. And that means they can't be as productive as they need to be.

Dr. HUELSKAMP. All right.

Thank you, Mr. Chairman. I yield back.

The CHAIRMAN. Dr. Ruiz, you are recognized.

Mr. RUIZ. Thank you, Mr. Chairman and Ranking Member, for holding this hearing.

Thank you to our guests for being here.

My question is more in line with the implementation of the Choice program.

So we have some money that you want to take from that program and put it into other non-VA care and other types of care. And I am always of the view that we need to take care of our patients, take care of the VA. So if you need to take care of them by purchasing more medications for certain ailments or illnesses, then that is what we have to do.

However, what I am concerned about is why there is this money that is not being utilized with the Choice program, when I know, in my district, after speaking with 70 specialists in high-demand specialties with the TriWest and Loma Linda VA, like other members here have done, that there is not a clear understanding of the process or of the implementation or outreach. There are no education efforts by the VA as much as we would like to see. And so the actual implementation is, you know, very slow and not very efficient and effective.

So why is there money left over now from that Choice program? And is that money that could be used with the implementation of the Choice program?

Mr. GIBSON. Well, I think we are on the same wavelength here, actually.

First of all, a fine tune: We are not looking to move money out of Choice. We are looking to be able to use Choice funds to pay for care in the community. So we don't want to move it someplace else; we just want to be able to access it to pay for care in the community.

In the opening statement, I went through a litany of seven or eight different factors that have gotten in the way. Many of them have to do directly with the implementation of Choice.

I was actually surprised the other day in one of our daily standup meetings on access to care when folks were describing to me the 5-year process that has been underway to put in place the procedures for utilizing care in the community, our old traditional program. And they are still working on them after 5 years.

We roll Choice out in 90 days. And, you know, I am reminded that, when we first went to the industry about Choice to look for third-party administrators, they said, what you are talking about is going to take 18 months to put in place. And the idea that we would put it in place in 90 days, they said it will never happen.

And I think, 8 months into this, part of what we are learning is the time required to recruit providers, the time required to change internal processes, the fact that every one of our processes has different payment mechanisms, many have different reimbursement rates, as we have alluded to before—I think every one of these issues have gotten in the way of our ability to route care to Choice.

But, as I mentioned before, day by day, that penetration into Choice is improving.

Mr. RUIZ. So how about the idea of maybe consolidating these seven different community care programs——

Mr. GIBSON. Yes.

Mr. RUIZ [continuing]. And streamlining them——

Mr. GIBSON. Yes.

Mr. RUIZ [continuing]. And doing similar processes?

Mr. GIBSON. Yes.

Mr. RUIZ. Is that underway?

Mr. GIBSON. That is exactly what I referred to in the opening statement. We want to do precisely that. We are going to need Congress' help to do that.

Do you want to make a comment on that, too?

Dr. TUCHSCHMIDT. Yes.

I was going to say, so we have actually informed the field that we want Choice to be the number-one mechanism by which we send people into the community for care.

We have work to do, we know that, to try and streamline some of those processes. We are training our staff today in some of those streamlined processes so that we will do more coordination of that care, the way we have in our purchased care programs in the past. But that movement to streamline those various channels is already underway.

Mr. RUIZ. You know, whenever a system wants to change, they usually have champions or coaches that go into, like, a hospital or something else. I think that there should be some coaches that go into a community or a region and help set it up for the providers, set up training for the veterans, and also work with the Members of Congress so that we can help others do that same thing.

Dr. TUCHSCHMIDT. I think you are absolutely correct. And, as I said earlier, TriWest, for example, and our folks are going around the country meeting with providers in the community, trying to get those providers to sign up to be Choice providers. And I think that has been a pretty successful effort on our part. And I have to laud TriWest because they have worked very hard to try and make that work.

Mr. RUIZ. Thank you.

The CHAIRMAN. Okay, members, we are going to take a short recess. We have two votes. We will resume the hearing immediately following the last vote.

[Recess.]

The CHAIRMAN. Okay, members, if we could resume the hearing. We have members that are still making their way back from the last series of votes.

I thank everybody for your indulgence.

Ms. Kuster, are you prepared to go ahead and begin with your line of questions?

Ms. KUSTER. I am.

The CHAIRMAN. Ms. Kuster, you are recognized.

Ms. KUSTER. Thank you very much.

Thank you to our witnesses for being here.

I was just looking real quick for an email that I just received from New Hampshire and wanted to thank you because it is a little bit of good news. We have signed up an important community part-

ner of ours in the north country in New Hampshire, a sparsely populated area with lots of veterans, to be part of the Choice program.

And I just wanted to reference that because we have talked quite a bit today about this transition and how long it takes. And part of that, I know, is to line up these private community partners, healthcare providers, and, particularly, as we get into care for seniors, adult daycare, as we get into home care.

Where I want to go, if we could, is looking forward, because I think we can all agree and there is bipartisan concern about this transition, but some of my colleagues may not be familiar with this notion of the other six types of programs. And as I have sat down with my VA, we have talked about when the Choice program is applicable, when the other programs are applicable.

And it seems to me there is a multitude of dimensions, but if we could just take two, one is the availability of services, so whether it is a network or whether it is a local provider that is willing and able and available to provide service. And the other, not surprisingly, is cost, and both the cost to the taxpayer to provide the service, but also I think you made a really important point for people to understand about the out-of-pocket cost to the veteran. Because until we have an understanding of these decisions that are being made, we are not going to grasp the dimension of opening up access.

And we had a note in our memo that said, previously, the VA has controlled access through distance and delay. And that is the reality, right? We made this promise to our veterans, and then the way we kept a lid on the cost of it to the taxpayer was that for most veterans it was either too far away or it took too long to get the service.

So help me, going forward, with your magic wand here, with the change that Secretary McDonald and you, Mr. Gibson, and others are bringing to this unwieldy organization, what would be the path forward to streamline these programs, provide direction within each of these different VISNs in each of these different communities, and get access to the veteran in a way that is timely and high-quality and cost-effective and efficient for the taxpayer?

Mr. GIBSON. If I could ask Dr. Tuchschmidt to start out on that one, because he has done an awful lot of work precisely in this area.

Ms. KUSTER. And I don't want to get too complex, but what is it that you to need from us? Is this going to be a congressional change? And how can we get together with you in a bipartisan way to make that happen?

Dr. TUCHSCHMIDT. So we have been working, spending really almost the last year since the legislation was put in place in November, working with Deloitte. We asked them to bring their commercial side of their business in to look at our business office and how we manage care in the community against and benchmarked against best practices in private-sector health insurance industry. They have helped us identify core competencies, and they have done a maturity assessment against best practices in the private sector.

We have taken that and are developing a plan to really make sure that we can build all of those competencies using our current

business office function as the foundation on which we will build, over the next year or so, some of those competencies.

We will have to make some decisions about do we build that ourselves or do we buy that. Because that expertise is out there, and it is, you know, more cost-effective and more efficient to go out and buy it.

We have a group right now looking at our TPA processes to say, going forward, what do those look like, how do they change, what do we want to put into the TPA contract in the future to be able to build some of those competencies and really run a much more robust program.

I think part of what we are going to need help with is, in fact, rationalizing some of these programs. I mean, I think, ultimately, we would want Project ARCH probably folded into the Choice program so that, you know, we can get rid of some of these multiple channels.

And I think we are going to need some changes to the Choice Act itself, the way the Choice program is structured. I think we have alluded to those changes several times, about Medicare providers versus providers that we believe are qualified to deliver that care, those kinds of things—60-day authorization periods.

I think us being the secondary payer under Choice is problematic. And it is very problematic in places where—I was just a couple weeks ago in Alaska talking with the DoD folks and now are engaged with Dr. Woodson and his folks. That is really problematic if we want DoD to be providers for us.

So I think we have——

Ms. KUSTER. I have to tell you, my time is well past up. But this direction, I would love to get a briefing going forward, if we could——

Dr. TUCHSCHMIDT. Absolutely.

Ms. KUSTER [continuing]. And if we could stay on top of that. Thank you.

And I apologize to the chair.

The CHAIRMAN. Thank you very much.

Mr. Coffman, you are recognized.

Mr. COFFMAN. Thank you, Mr. Chairman.

Secretary Gibson, so what we are, in effect, talking about is the shortfall in your budget available for healthcare.

Mr. GIBSON. Correct.

Mr. COFFMAN. So, if we look at the VA historically, I think initially it was for service-connected issues for our military personnel, not means-tested. Then we expanded that at some point to low-income veterans on a means-tested basis. Then we expanded it again at some point to give automatic eligibility to our returning Active Duty leaving for civilian life that is not means-tested. I can't remember if that is 4 or 5 years that they have eligibility.

But in March of this year, VA announced that it would no longer use the net worth or the asset test to determine VA eligibility, thus expanding it again. But you did it at a time where the money—it is my understanding you have the statutory authority to do that, but you have to make an assessment of whether you have the resources available to meet that expansion of eligibility. Clearly, you don't have it. And so what are you going to do about this?

Mr. GIBSON. You know, I am going to have to follow up on this one for the record.

Mr. COFFMAN. Okay.

[The information follows:]

Mr. GIBSON. But my understanding was, what we did is we were able to substitute other means tests that we were able to access directly, either from the IRS or the Social Security Administration or something like that, in place of an annual requirement on the part of a veteran to file about net worth.

So it is my understanding, and we will go validate——

Mr. COFFMAN. Sure.

Mr. GIBSON [continuing]. This and come back to you for the record, but it is my understanding that this wasn't a move to open the aperture. It was actually a move to relieve a burden, an administrative burden, on the veteran.

Mr. COFFMAN. Okay. We need to find that out. Because I got this information through a veterans magazine, one of the VSOs, and they were touting it as an expansion of eligibility by virtue of relaxing the asset requirement and making more individuals eligible for—well, they would be eligible anyway, but they would have to pay for a portion of their care. This would relax that requirement. And so, obviously, then, it is an expansion of care. I think you would assume that more people would go through it.

If you would look at that and get back to the committee on that, because I think that is a concern where we don't have the resources to meet our current obligations; we really can't expand eligibility to new populations.

Mr. GIBSON. I think you are absolutely right. I agree with you. And we will follow up for the record.

Mr. COFFMAN. Mr. Chairman, I yield back.

The CHAIRMAN. Thank you.

Mr. McNerney.

Mr. MCNERNEY. Well, thank you, Mr. Chairman. And thanks for bringing this to light, this hearing, such a subject.

I am going to ask a couple of parochial questions, first, if you don't mind.

Given that cost overruns and mismanagement continue to be a problem, do you feel that the VA could benefit from the expanded use of public-private partnerships for major construction projects, where the VA allows non-Federal stakeholders and construction experts to work on projects?

Mr. GIBSON. The short answer, relatively less informed, is yes. In fact, Secretary McDonald and I met, I think, about 2 weeks ago with the leadership of the Association of General Contractors and a number of large and smaller contractors that work with us on a regular basis. This was one of the very specific topics that we talked about. And, in fact, we have agreed to come together to look at specifically those opportunities.

We are also actively considering an opportunity in San Francisco on a specific project for public-private partnership.

Mr. MCNERNEY. Okay.

Will the cost overruns of the Denver Medical Center cause a delay of the French Camp community-based outpatient clinic and

other major construction projects that the President has prioritized in his fiscal year 2016 budget?

Mr. GIBSON. I don't expect that what we are doing in Denver is going to have any adverse impact on any of our major lease transactions.

And depending on the ultimate funding source that we wind up working out with Congress, with both the authorizers and the appropriators, I can't unequivocally say that it won't affect some major construction projects, because that is at least one of the options that has been on the table. But I think there is a strong desire on the part of Congress for us to not adversely impact those projects. So I think it is less likely that we would see that as a source of funding.

Mr. MCNERNEY. Well, in April, there was an announcement about 15 projects, major projects. Five of them were going to be too late for the Corps of Engineers to be involved in. Five of them were still being questioned.

Do you have an idea of which projects are still being under consideration?

Mr. GIBSON. In terms of engaging the Corps to become our construction agent, there were five that the Corps and VA had agreed were too far along for it to make sense for the Corps to take on. I think we have taken the number from five up to seven on the ones that we have agreed with the Corps we would turn over to the Corps for them to be the construction agent and three that were relatively smaller transactions that we felt like made the most sense for us to hang on to.

Mr. MCNERNEY. Could you identify which ones are which?

Mr. GIBSON. We will get that for you.

Mr. MCNERNEY. Thank you.

Mr. GIBSON. Be glad to. We have the lists. In fact, he may have it in his book over here, so if he does, we will give it to you before we walk out the door.

Mr. MCNERNEY. And I am not sure whether this question has been asked before. What is the price deferential between a VA medical service versus non-VA medical services by whatever metric you may have?

Mr. GIBSON. I am going to defer to our clinician here.

Dr. TUCHSCHMIDT. I am not sure. I don't have that in my head. But we can take that for the record and get that information.

[The information follows:]

Mr. MCNERNEY. Okay. Well, following up, what about healthcare outcomes? What is the difference in healthcare outcomes from VA-based service versus non-VA-based service for veterans?

Dr. TUCHSCHMIDT. So, again, I don't know that we actually have our own data around that. But there are plenty of research studies that have been done looking at outcomes between private sector and VA and basically have found that the quality of those services are comparable, whether it is in the VA or outside the VA.

Mr. GIBSON. One of the things I would suggest that we do, let's plan on a SAIL briefing for the Congressman. This is the comprehensive tool that we use to evaluate care quality, patient safety, access, patient satisfaction. And many of the metrics that we use

are metrics that are also used in the private sector, so we have the ability to be able to compare across VA and the private sector.

And we will get somebody like Peter Almenoff to come give you a briefing.

Mr. MCNERNEY. That would be very informative.

How about the outcomes of the new hepatitis C treatments? Are those showing good healthcare outcomes?

Dr. TUCHSCHMIDT. Well, it is very early to assess that in the process. Most of these are months courses of therapy. But all of the studies that were done to approve these drugs show that they have very high cure rates, much higher, with much lower side-effect profiles than the drugs that we had in the past.

Mr. MCNERNEY. So, I mean, since so much resources are being expended in that direction, we need to have a pretty clear understanding that it is actually showing improved results.

Dr. TUCHSCHMIDT. Right.

Mr. MCNERNEY. Thank you, Mr. Chairman.

The CHAIRMAN. Dr. Wenstrup, you are recognized.

Dr. WENSTRUP. Thank you, Mr. Chairman.

And thank you all for being here today.

I want to expound a little bit upon what Mr. McNerney was asking about when he was talking about cost, VA versus non-VA. And we have had this discussion before, and, at one point, you told me you are a ways away from really being able to assess that.

And I think one of the best ways is how much are you spending per RVU that you produce. And by that, I mean your physical plant, your supplies, your administrators, your employees. Because that is what a private practice has to do.

And I assume we are not at that point yet. Would that be correct?

Mr. GIBSON. I don't think we are, but I think we are getting closer.

Jim.

Dr. TUCHSCHMIDT. I mean, we have done cost per RVU based upon—so the data that I am about to quote I think is based upon, you know, our salary and benefits direct costs, so it is equivalent to what we would be paying the provider. And our cost per RVU is much lower than the private-sector benchmark.

Dr. WENSTRUP. Well, sure, it probably would be. But you are not taking into account what the private-sector person is paying for, for their insurance, for their staff, for their supplies, for their physical plant, all those things. That is how you can really evaluate what you are paying for RVU.

Because in a business model, which is really what we are trying to get to here, which—I don't think the VA was ever in one before—if we want to get to that point, you have to be able to assess. Because at some point you have to say, you know what, we have more buildings than we need, or we need more buildings than we have, to be more productive. I mean, that is really where we need to be headed.

And that is why you have to take into account all of those things, because that is what that private person is doing. When the VA pays that non-VA provider, they are not accountable for all those other expenses——

Dr. TUCHSCHMIDT. Right.

Mr. WENSTRUP [continuing]. That that person takes in. So we are not really comparing apples to apples unless we do that.

Dr. TUCHSCHMIDT. Right.

Dr. WENSTRUP. So hopefully we will continue to proceed in that direction so we can make wise decisions together as to how we go forward. You know, and we need to keep looking for—how do we reduce our fixed costs and still provide the same level of care?

One thing I was encouraged about today, increase in RVUs 10 percent. Can you tell me how you did it?

Mr. GIBSON. I think it is a combination of factors. We have gone—and, for example, I alluded to extended hours, which has allowed us, in many ways, to make more efficient use of our space.

We have gone in and scrubbed primary care panels. We have gone in and looked at appointment grids. We have gone through that kind of scrubbing process.

We have developed a couple of different productivity assessment tools that now push this data all the way out to the individual medical center, down to the clinic, down to the provider, so that we are able to look and see how relatively productive a particular clinic is in relation to the volume of appointment activity and the demand for care. And folks are beginning to now make adjustments based on that. They are realizing that they have excess capacity that they are not utilizing.

Dr. WENSTRUP. Are we reaching out to the providers and asking them, what is it that you have to do that makes you less efficient as far as seeing patients? You know, what is it that we can do?

We talk about things like, you know—you are working out of one treatment room. We know that is inefficient, right? So we need that feedback from the providers, especially ones that have been in private practice, to say, you know, you are eating me up with doing X, Y, Z, restocking the cabinets, when I should be seeing patients, those types of things, and all the way up the line.

So I hope we are getting good provider input.

Mr. GIBSON. My sense is that we are. I get it when I am out in the field. I know, as we look at different particular initiatives—we undertook a major initiative a year ago to look at support staff for our specialty providers, which gathered vast amounts of input from providers out in the field, with the obvious conclusion that we were way underleveraging our specialty providers. So one of things we have been doing is ensuring that we are adding support staff into our specialty clinics, as an example of that.

Dr. WENSTRUP. Thank you.

One other thought I had, too, with one of the things you said today, you know, a lot of veterans do choose to go to the VA. They want to be at the VA. And there are a lot of veterans who have other care—private insurance or whatever the case may be.

If the VA is their choice, why don't we bill their insurance, get on their plan? They have insurance somewhere else. And, you know, a lot of veterans don't use VA because they want more funds to be there for those who need it more.

Mr. GIBSON. You are singing Jim's song here.

Dr. TUCHSCHMIDT. Yeah. And we do—so today we do—if they have private insurance, we do bill their insurance. Sometimes that

is Medigap coverage, which without an EOB, Medicare EOB, we don't get paid. And then we don't have the authority to bill Medicare or Medicaid or TRICARE.

Dr. WENSTRUP. Well, Medicare and Medicaid is robbing Peter to pay Paul, as far as the big picture of taxpayer dollars, et cetera.

Dr. TUCHSCHMIDT. Right.

Dr. WENSTRUP. But private insurance is a different story.

Dr. TUCHSCHMIDT. We do bill those. And, in fact, those collection rates have been going up steadily year after year after year.

Dr. WENSTRUP. Thank you very much.

I yield back.

The CHAIRMAN. Dr. Abraham.

Dr. ABRAHAM. Thank you, Mr. Chairman.

And thank you for being here, gentlemen.

I guess a statement first on just fiscal responsibility. I was reading in the IG's report last week, and I think he said that the VA didn't know they had $43 million in an account, and all of a sudden it was just found after it had been sitting there for 3 years. So that is, you know, somewhat of an astounding thought.

And then I look at the Choice Act, and correct me if I am wrong—I read the act—that there are $360 million put aside in the Choice Act for awards and bonuses and that type of deal. Now, you know, being a businessman, I totally support a bonus, an award, when it is appropriate. But if that is an—is that an accurate figure?

Mr. GIBSON. I think what you—no, it is not.

Dr. ABRAHAM. Okay.

Mr. GIBSON. There is no money set aside in Choice for bonuses. What you may be referring to are the caps on the cost associated with administration of the plan. It is basically——

Dr. ABRAHAM. Is that $360 million? Is that an accurate figure?

Mr. GIBSON. I want to say the initial tranche was $300 million, if I am remembering right, which is now somewhat higher than that. But it is the money that we wind up paying the third-party administrator for basically administering the——

Dr. ABRAHAM. The program.

Mr. GIBSON. Yes, sir.

Dr. ABRAHAM. Let's talk a little bit about the lack of non-VA providers, or getting them into the Choice program, of a non-VA provider. And I think you had brought up the subject of the rate being paid.

What I am seeing in our district in Louisiana—and you have addressed this in a previous hearing, and we will kind of redress it again—is not the rate but just actually getting paid. And I was in the district last weekend and had three separate providers come up and say, I haven't gotten my money, and this has been going on for 2 and 3 years.

So what are we doing about that, Secretary? I know that you gave us some good figures before, that the VISN 16, which I am a part of, was doing better.

Mr. GIBSON. Yes.

Dr. ABRAHAM. But the word on the street, so to speak, is there are still some issues out there.

Mr. GIBSON. Two things.

First of all, that is one of the advantages of Choice. The provider gets paid by the third-party administrator. And that has consistently happening within 30 days. We watch that and monitor that. VA has historically been known to pay low and slow. And that is not how you want to deal with your provider network.

Dr. ABRAHAM. So we have something in place that that is going to get better?

Mr. GIBSON. And so what we have done over the last 9 months or so is organizationally consolidate. We were organizationally doing this payment processing through 21 separate VISN headquarters in 70 different physical locations, processing invoices for care. And I would tell you, based on what I have heard, we were probably doing it in 150 different ways.

And so we have consolidated organizationally. We have begun to tackle the staffing issues, the process issues, and the technology issues, none of which were being tackled unless they were being addressed in some kind of a workaround situation in some location somewhere.

We had, for example, locations where, instead of establishing a call center that is available to handle inbound questions from providers about their payment, we would have a processor that is processing a payment, and then the phone would ring, and they would answer the phone and, you know, doing business in a way that you would never see in the private sector.

Dr. ABRAHAM. Correct.

Mr. GIBSON. So we now have that all organizational reporting. We are seeing the times improve. Part of what they are doing is they are sailing into a headwind. They have a 40-percent increase in invoices being presented for payment over last year. Now, the good news is they are processing a lot more invoices than they did a year ago, but they are barely keeping up.

We have made progress in VISN 16, though.

Dr. ABRAHAM. Okay. Thank you.

And one real quick question, because I am running out of time. The hepatitis C money for 2016 and 2017 that you are projecting, do you think you are pretty much spot on, or do you think you will need to come back to us and say we need more money?

Mr. GIBSON. We are short in 2016. You know, the budget is, what, $650 million, somewhere in that neighborhood, $650 million to $700 million for 2016, and that won't be adequate unless we ration that care.

The other option is, as we are doing right now, is basically when we run out of money to do it inside VA. We refer those to care under Choice and rely on that sort of safety valve.

Dr. ABRAHAM. Okay.

Thank you, Mr. Chairman.

The CHAIRMAN. Thank you very much.

Ms. BROWN. do you have another question?

Ms. BROWN. I do. However I will pass so, I can be last on my side.

The CHAIRMAN. Mr. Takano, do you have another question?

Mr. TAKANO. Yes, I do. Secretary Gibson or others or Dr. Tuchschmidt, I want to continue some of my line of questioning on the hepatitis C issue. Right now, you don't ration hepatitis C care,

you don't see the need to. And I want to get some idea about the experience of, say, a veteran who has hepatitis C, does the physician within the VA have full discretion about when that medication is supposed to be accessed or prescribed? Is there an internal process?

Dr. TUCHSCHMIDT. So we have guidelines that we have published for the treatment of patients with hepatitis C and the new drugs, both specifying when certain drugs should be used, as well as kind of a hierarchy of people who have advanced liver disease should be treated first, et cetera. But the decision to treat or not treat is an individual decision between a clinician and a patient.

Mr. TAKANO. So the doctor, the physician has a considerable amount of autonomy in terms of making this decision. I have been reading disturbing cases in the L.A. Times recently about a woman who has been, and her physician and they are battling the private insurer. The insurer would rather provide the medication at a later stage of the disease. And, in this case, and I don't know what the experience is for people in Medicare, whether they are in traditional Medicare or Medicare Advantage Plans, but at least in the VA, you are telling me that the current situation now is that the physician's judgment is pretty much honored?

Dr. TUCHSCHMIDT. Yes, we respect the clinician judgment. There are many places in Medicaid, which will not cover the new drugs. There are some private insurances that do and some private insurances that don't. We have covered those drugs. And for the patient who has advanced liver disease as a result of hepatitis C, I mean, you are at risk of cirrhosis. You are at risk of liver cancer from the hepatitis C virus. If you have advanced liver disease, you are definitely a candidate for therapy. If you are infected but don't have active liver disease, right now, you are kind of lower down kind of in a priority list perspective. But as a patient, I potentially am infectious to other people. So I am infectious. It is a bloodborne disease, through contact with my wife and my kids and other people in my household, people I might be working with, et cetera. So I think you may not have active liver disease, but you may still as a patient have a lot of concerns.

Mr. TAKANO. Secretary Gibson, you were reluctant to reveal what you actually pay for this drug. Is my understanding correct that we have just one manufacturer that manufactures the hepatitis C drug? Or are there more than one manufacturer?

Mr. GIBSON. There is more than one manufacturer.

Mr. TAKANO. Okay. I was under the understanding there was only manufacturer and maybe one patent. I didn't realize there was this competition.

Mr. GIBSON. There is multiple manufacturers of multiple drugs, but they each make one patented drug.

Mr. TAKANO. I see. Now, my understanding is that Medicare can't negotiate in the way that the VA can and that Medicare spent $4.5 billion in hepatitis C treatments, 15 times over what it spent the year before. I don't know what the experience of the VA is or just what you are spending per patient because I realize you are not willing to reveal that. And I am looking at what people are experiencing with private healthcare insurance. It seems to me that people are making some rational decisions, especially our seniors

that our veterans, who are low income, that they are probably getting access to a doctor who can make a decision and not have to wait on an insurance company and that, in this case, the VA is providing a much more superior service to those veterans.

And you mentioned, Secretary Gibson, the case of knee replacement, the out-of-pocket costs. I am just wondering what the out-of-pocket costs are for the seniors who are limited to Medicare if they have to get this hepatitis C medication versus the veteran.

Mr. GIBSON. My understanding is that Medicare has an annual cost ceiling of $7,200. And somebody that is more expert than me can correct that. And so that would be, you would get capped out at that amount under Medicare.

Mr. TAKANO. So the senior would have to pay that difference?

Mr. GIBSON. Yes.

Mr. TAKANO. Wow. For that low-income senior, that would be a big problem.

Mr. GIBSON. It is clearly a very strong incentive. And it applies not to just this hep C treatment but it applies to whatever a veteran may be pursuing. There is some preventive treatment that Medicare has no copay on. And so, in that instance, the veteran truly has a choice without any different economic consequences. So he can go to VA or he can go to his private provider and use Medicare. But if it is a procedure with the copay, then the veteran is going to be making a rational, economic decision, as you are referring to.

Mr. TAKANO. Mr. Chairman, I yield back.

Ms. BROWN. May I respond to your comments?

Because I don't think you were here when we passed the prescription drug bill. When we passed it, we directed the Secretary not to negotiate the price of the drugs. That was a part of the bill.

Mr. TAKANO. Oh, Ms. Brown——

Ms. BROWN. It would be the illegal for the Secretary to address that issue. I am just clearing up what happened. You weren't here when we did it. But in addition to that, in the Affordable Care Act that is now standing, we are doing away with that doughnut hole that you are talking about so seniors will not be out of pocket for that additional money.

Mr. TAKANO. Ms. Brown, I was aware of that. And I was merely trying to suggest that the VA is doing business in a better way.

Ms. BROWN. Oh, absolutely. Thank you.

The CHAIRMAN. Ms. Radewagen, do you have any questions?

Ms. RADEWAGEN. Thank you, Mr. Chairman and ranking member.

Good afternoon, Secretary Gibson. And thank you for your testimony, especially about the improvements in access to healthcare for all veterans. I would also like to extend my sincere thank you to you and Secretary McDonald for sending Dr. Wayne Pfeffer, Medical Center Director for the VA Pacific Islands, to represent your Department during the most important holiday in American Samoa, Flag Day, commemorating the 115th anniversary of the raising of the United States flag on our island.

It meant the world to our veterans. So thank you very much. I will be very brief. I don't know if you are aware of some of the shortages of medical personnel affecting the services being provided

in our VA clinic back home in American Samoa. For example, we have got audiology equipment on hand in the clinic but no specialist to operate it. We also have brand new physical therapy equipment on hand but no PT specialist. So I was wondering how many, if any, of those new VHA staff members you hired were for the VA clinic in American Samoa?

Mr. GIBSON. I am not able to answer your question off the top of my head. I see Dr. Tuchschmidt writing over here, and I am sure there are some folks behind be writing. We will get you an answer back to let you know.

And I will also look into the vacancies in our clinic there.

Ms. RADEWAGEN. Okay. Thank you. I had another quick question. How can VA improve its budget planning to ensure that the Department is better able to anticipate and react to higher than expected demands for care and/or increased costs of medications or other necessities?

Mr. GIBSON. That is a great question. I alluded in my opening statement to the challenges that we have as a Department forecasting reaction to improving access, being able to forecast changes in reliance on VA care, and then being able to factor into those forecasts information about market penetration, where we look at the number of veterans in a particular market, how many are enrolled for care at VA.

I happen to know from my early visits to Phoenix that Phoenix was dramatically underpenetrated in the market. So there is a part of me that looks at the kind of response that we saw, that I described earlier, that is not necessarily surprise. But we don't typically factor those elements in or measure them very effectively. I think when we go through a process like we are now, where we are dramatically improving access to care in a relatively short period of time, it is giving us an opportunity to gain better insight and understanding and data.

So that as we are forecasting future instances, we are able to look at those and understand a little bit better what the anticipated response might be. And I would tell you, lastly, on medications, I think the lesson, one of the lessons we have learned from hep C is very early on where we identified what you might characterize as blockbuster drugs that have a high price tag is that we start thinking and building into our planning as early as we possibly can the potential financial impact of those. There are a couple of cardiology drugs that are in the pipeline right now that are supposed to be blockbusters coming down the pipe that we are already talking about and trying to make allowances for.

Ms. RADEWAGEN. Thank you.

Dr. TUCHSCHMIDT. If I could just add to that, I think today we use one of the best actuarial firms in the world, Milliman, to do our modeling and projections. I think those models work well in very stable environments. But when that environment is perturbed by changing the benefit structure in some way, it becomes very hard to predict. And I think we have been doing a lot of work to look at and try and understand what would happen if we, a lot of interest in making the 40-mile benefit 40 miles from a place that can deliver that service, we have been doing a lot of work to try and understand what that does that look like. But you have to make

a lot of assumptions that may or may not be correct. And I think that in very dynamic, fluid conditions, it is very hard to do some of the modeling that you might be talking about.

Ms. RADEWAGEN. Thank you.

Thank you, Mr. Chairman. I yield back.

The CHAIRMAN. Thank you very much.

Ms. BROWNLEY. For a very short question.

Ms. BROWNEY. Thank you, Mr. Chairman and Ranking Member, for your indulgence. I really appreciate it. I had highlighted earlier in my earlier testimony some of the impacts that my district is already feeling. One of the other issues that they raised too was that the C&P evaluations are beginning to slow down as well. I know the folks the work in my congressional office are feeling that impact. I think you have said that $600 million, you found $600 million, I am wondering will that $600 million begin to mitigate these impacts that my district is feeling in the short term? And then if Congress doesn't act on the fiscal year 2015 budget shortfall, what is it going to look like in the VA in July and August and on October 1.

Mr. GIBSON. I think the number I should have used, $348 million, is the amount of the—that we have provided Congress notice on that we intend to transfer into cover additional costs for care in the community. I think the farther we go in the fiscal year without the ability to open the aperture and utilize additional Choice funds, we get into very dire circumstances. Before we get to the end of August, we are, we are in a situation where we are going to have to start denying care to veterans in the community because we don't have the resources to be able to pay for it. And that is, I don't think anybody wants to see that happen. It will be a very unpleasant and unsatisfactory situation.

Ms. BROWNEY. And will you be giving us any of that information so that we have, you know, the real data to understand what those severe impacts are?

Mr. GIBSON. As best as we can, I am hoping that we wind up not having to go there and that we are able to use Choice dollars that were appropriated for care in the community to pay for care in the community. And if that is the case, then I think we are going to be absolutely fine. And we are going to be able to sustain care for veterans, even in the context of this increasing demand that we are experiencing. I think failing that, yes, there will have to be an awful lot of communication that goes all the way down to the medical center level so that Members understand what is happening in their particular districts.

Ms. BROWNEY. So, with this transfer of money, 358, whatever you said it was, can I go back to my district and tell my folks who are waiting for adult daycare that we have got some extra money, and we will be able to address their issue?

Mr. GIBSON. Part of what we are going through right now is some leveling across all of our different locations. So a lot of that is happening inside of VISN, where a VISN may have one center that has got some additional resources available, more than another medical center would. So there is leveling happening there. There is leveling happening at the top of VHA. We are going to continue to look internally in the very short term for opportunities

at the top of VHA that we are able to distribute out to the field while we are waiting for the appropriator's nod on the additional $350 million that we have asked that they allow us to transfer. So it is hard for me to say at this point down to an individual medical center level: Here's what that $348 million is going to mean to you.

Ms. BROWNEY. Thank you, Mr. Secretary.

And thank you, Mr. Chair.

The CHAIRMAN. Thank you.

Ms. BROWN. For some final comments.

Ms. BROWN. Thank you. I am going to say right up front that I don't support across the budget cuts. I would not be supportive of across-the-board cuts. We gave you all $15 billion, and you have $5 billion is that for healthcare?

Mr. GIBSON. For staff and facilities, yes, ma'am.

Ms. BROWN. I thought it was just for veterans' care. Did it just say for——

Mr. GIBSON. There is $10 billion for veterans' care, $5 billion for staff and facilities.

Ms. BROWN. I need to know what it is that you need from us, the Congress, what do you need us to do to put VA where it needs to be? I don't want a constituent calling me saying we are not providing care for veterans. That is unacceptable.

Mr. GIBSON. Yes, ma'am.

Ms. BROWN. When I talked to my colleagues on the floor, they say: We don't understand what is the problem, we give you everything you all asked us for, and so I am at that page too. If you ask us and say this is what you need, I am going to fight for it. I don't want my veterans saying that we are not providing care. I have read those stories about me and my district.

Mr. GIBSON. Yes, ma'am.

Ms. BROWN. When you opened up the clinic in my district, then it just, the demand went through the roof.

Mr. GIBSON. Yes, ma'am. Yes, ma'am.

Ms. BROWN. So help me here.

Mr. GIBSON. We owe you a formal request. The specific request in the context that we are talking about here is a request to allow VA to utilize Choice program funds, section 802 funds, to be able to cover costs for care in the community that might not otherwise qualify for Choice, meet those criteria for Choice. I think that will be the central feature of the formal request to Congress for support that will allow us to avoid disrupting care for veterans.

Ms. BROWN. I hear staff in the back of me saying the Committee are going to need a number.

Mr. GIBSON. Well, the number that we have offered and that was included in my testimony is $2.5 billion. That is the forecast—it is not what we are in the hole today—it is the forecast as we continue to deliver care in the community between now and the end of the year of what our shortfall would be.

Ms. BROWN. I am confused. If we give you $2-point-something billion or give VA the authority to move the money around, will it stop the calls I get from veterans saying they are being denied care? Because that is how we got to the $15 billion is because we want to take care of the veterans. When we send them to war, we have an obligation and a responsibility to take care of them.

Mr. GIBSON. We agree and we feel that same sense of obligation. What the $2.5 billion will do will allow us to basically continue on the path that we are on right now. But as I mentioned earlier, every step we take to improve access to care, much like your comment about opening a new outpatient clinic and the demand goes through the roof, that is the same thing we are experiencing across VHA.

We do something, whether it is additional staffing, additional facilities or space, whether it is improving productivity so that we can provide appointments more quickly and what happens is all of that additional capacity gets more than consumed with additional demand. And that is why the total wait times are up. It is the accelerating demand that we are dealing with.

So you may still get a phone call from a veteran that says I am not getting timely care. And the veteran is going to be right because he is not getting timely care. That is because we improve access to care as fast as we can and the demand grows even faster.

Ms. BROWN. Well, if that veteran wants care at the VA, it may not be in the time that he wants. But if he wants Choice, he or she wants Choice, that should be within 30 days.

Mr. GIBSON. It absolutely should. And if we get the additional flexibility so that different kinds of care are Choice eligible, then you are absolutely right, there shouldn't be a reason for a veteran to have to wait if he is willing to go get care in the community. You are right.

Ms. BROWN. Thank you, Mr. Chairman.

The CHAIRMAN. The one thing that I am a little confused about as it relates to the shortfall, you have talked about in your testimony when you use mitigating factors is the shortfall of 2.6 or 2.7, whatever the number is, is that after you have implemented the mitigating procedures?

Mr. GIBSON. The $2.5 billion basically assumes, the biggest mitigant is that we are successful in shifting care into Choice. That is the biggest factor. And we think, we think that the current estimates are that we may be able to shift $500 million worth of Choice-eligible care, based on today's eligibility criteria, into Choice between now and the end of the year. That is included in the $2.5 billion. So if we were successful in doing that, that number comes down to $2 billion. But it is still basically a pool of $2.5 billion for care in the community where we want to be able to sustain that care for veterans.

The CHAIRMAN. Very good. And one thing that concerns me about the answer to one of the questions where you talked about with Mr. Takano getting to a point where you are going to have to begin rationing care to folks with hepatitis C, I hope it was not your intent to infer that you would not go to something that you have already testified today to the fact that you can go in and take money out of the bonus program to plug that budget hole if necessary. Surely, you would choose to draw money out of the bonus plan in order to provide hepatitis C drugs and not keep that program whole and cause veterans not to get treatment.

Mr. GIBSON. We are not doing any rationing of care today. We don't expect to do any rationing of care with hepatitis C. The thing that is allowing us to do that, frankly, is Choice. If we can't pro-

vide, if we don't have the resources to provide the care within 30 days, then we refer that veteran to a provider in the community. We stay close and work——

The CHAIRMAN. I understand that. But you are still dancing around the $360 million worth of bonus money that is sitting there that you can go to. And I don't want to hear anybody say we choose bureaucrat bonuses over veteran healthcare. And I know that is not what you——

Mr. GIBSON. I understand the point, yes, sir.

The CHAIRMAN. Everybody, thank you for being here. We wish you a happy Independence Day. We have another hearing in this room in 15 minutes.

So, with that, this meeting is adjourned.

[Whereupon, at 1:41 p.m., the committee was adjourned.]

APPENDIX

PREPARED STATEMENT OF CHAIRMAN JEFF MILLER

Thank you all for joining us for today's oversight hearing, "The State of VA's Fiscal Year 2015 Budget."

I called this hearing two weeks ago following a series of concerning and inconsistent reports from veterans and Department of Veterans Affairs (VA) employees in the field regarding the current state of VA funding.

I was not aware then of the troubling extent of VA's current budget crisis.

And, unfortunately, I suspect that had I not called this hearing, I would still not be aware today of the two point six billion dollar funding shortfall that the Veterans Health Administration is currently estimating, largely as a result of increased veteran demand for non-VA care and rising costs of Hepatitis C treatments that VA did not properly plan for or manage.

Given the extensive pent-up demand for care that was exposed during last year's hearings on wait time manipulation, VA had ample time to adjust its budgetary needs with the Office of Management and Budget to prevent what we are now seeing.

In February through April of this year, Secretary McDonald appeared at four separate budget hearings.

Since those have concluded, the Secretary and I have met and spoken regularly on a number of important, emerging issues.

At no point in those hearings or in our subsequent discussions since, has the Secretary expressed to me that the Department had a budget shortfall of such a magnitude—one that threatens VA's ability to meets its obligations to our nation's veterans.

Nor did other VA leaders or officials communicate how much in the red VA was either—even though the Committee was informed late last week that the Department knew as early as March that there were giant disparities between the amount of money that VA was spending and the amount of money budgeted.

The only message that Congress received in March regarding the state of VA's budget was the quarterly financial report VA submitted to the Appropriations Committee for the first quarter of fiscal year 2015, which showed that VA was actually under plan in terms of its spend out rate.

Meanwhile, just two weeks ago VA proposed a plan—that Congress authorized at the Department's urging—to transfer one hundred and fifty million dollars in fiscal year 2015 funding to support the continued construction of the replacement medical center project in Denver, Colorado.

VA also proposed an across the board recession of just under a one percent in fiscal year 2016 funds to devote to the Denver project—a proposal, by the way, that the Veterans Health Administration's Chief Financial Officer told Committee staff last week that she did not even know about until after it had already been transmitted to Congress.

Those actions clearly show that VA leaders believe that moving forward with the Denver project—which is not scheduled to open to veteran patients until 2017 at

the earliest—is a higher priority for the Department than ensuring that veterans who need care now are able to access that care.

I have come to expect a startling lack of transparency and accountability from VA over the last years; but failing to inform Congress of a multi-billion dollar funding deficit until this late in the fiscal year while continuing to advance what I believe are lower priority needs that further deplete the Department's coffers in support of a construction project that benefits no veteran for at least two more years is disturbing on an entirely different level.

Earlier this week, VA issued a "fact sheet" that claims that VA "formally requested limited budget flexibility" in February and March and May of this year and, "plainly articulated" VA's need for additional resources.

Buried on page one hundred and sixty seven of the second volume of VA's budget submission is a single statement that reads: "[i]n the coming months, the Administration will submit legislation to reallocate a portion of Choice program funding to support essential investments in VA system priorities . . . "

Secretary McDonald repeated this statement in his budget testimony without providing any additional supporting details or justification and, to-date, no legislative proposal has been submitted by the Administration.

In a May 12th letter to the Chairmen and Ranking Members of the House and Senate Veterans' Affairs and Appropriations Committees regarding the Denver project, VA stated that the Department, " . . . requests flexibility to make the [Choice] program work better for veterans through limited authority to use funds from Section 802 of the Choice Act to fund care in the community to the extent it exceeds our FY 2015 budget."

Again, no further information or supporting materials were provided.

If those two statements—absent any data or details—are what VA calls "formally requesting" budget flexibility and "plainly articulating" the Department's needs, then I understand why VA has found itself suffering nothing but string after string of failures in the last year.

What's more, it proves to me once again that VA's current problems reflect a management issue far more than they represent a money issue.

This Committee cannot help VA solve its problems, if VA refuses to be honest, upfront, and transparent with us and with the American people about the position it is in, the struggles it is facing, and the help that it needs.

Congress has consistently provided VA with the funding that the Department has requested and, as a result, VA funding has risen seventy three percent since 2009 while the number of Veterans using VA for care has grown by only about 2 percent per year, per VA's own testimony.

I know that I speak for every Member of this Committee when I say that we are committed to ensuring that VA has the funding it needs to deliver the world class healthcare our veterans deserve.

But VA must do its part—to confront and correct its poor budget planning and poor management issues, to hold poor performing executives and employees accountable, and—perhaps most importantly—to prioritize our veteran's needs over the bureaucracy's wants.

And if the current shortfall shows us anything it's that what our veterans need and want is to have a say in where and when they receive their healthcare.

Assuming VA's numbers are true, non-VA care appointments now make up twenty percent of all VA appointments, with veterans receiving more than one million appointments from community providers each month.

In the coming weeks, I will work with my colleagues on the Appropriations Committee to give VA the flexibility it is seeking to use a limited amount of Choice Funds for non-VA care and ensure that no veteran suffers as a result of VA's mismanagement of the generous budget the American taxpayers have provided.

However, going forward, there must be a dedicated appropriation account to fund non-VA care under a single, streamlined, integrated authority with a dedicated funding stream contained within VA's base budget—rather than the seven disparate, ill-executed non-VA care programs outlined in VA's testimony.

This morning, I look forward to discussing this proposal with Deputy Secretary Gibson and with my fellow Committee Members.

I thank you all for being here and I now recognize Ranking Member Brown for any opening statement she might have.

PREPARED STATEMENT OF RANKING MINORITY MEMBER CORRINE BROWN

Thank you Mr. Chairman.

Today's hearing is on the "State of VA's Fiscal Year 2015 budget." I can tell you all that the state of VA's budget is not strong.

The VA is facing a shortfall of $2.6 billion for veterans' healthcare. This shortfall must be addressed immediately. We cannot put the health and lives of our veterans at risk by spending our time and attention pointing fingers and assigning blame.

VA will be facing an additional shortfall at the start of the next fiscal year in October, a shortfall that will be made worse by the cost-saving steps VA is taking right now. We must address this upcoming shortfall.

I know that this Committee, as we have done so many times in the past, will work together to solve this crisis, and fix this mess. And I know that we all recognize that sometimes it takes more money to really fix a problem, and not just slap some tape on it and call it a day.

So, in the words of Deputy Secretary Gibson we will "get our checkbooks out." But I am concerned that there may be nothing left in the account as long as we continue to pretend that we can fund the essential requirements of government within arbitrary budget caps. We seem to be heading toward a government shutdown, and I am concerned over the effect such a shutdown would have on veterans seeking healthcare.

Ten years ago we addressed another VA shortfall. That shortfall was due to a lack of sufficient planning, and years of not providing the VA the resources it needed. Today's shortfall also seems to be caused by the lack of proper planning regarding the demand of veterans for VA healthcare. I am also concerned that inadequate planning led to insufficient resource requests.

We need to begin to fix these problems. My bill, the Department of Veterans Affairs Budget Planning Reform Act of 2015 passed the House in March 420–0. It is a much needed reform in how the VA plans and budgets for the future. It is time that our colleagues in the Senate pass this bill and send it to the President.

If the VA is going to be there for our veterans, then we are going to have to fix the problems. This will call for more than us just opening up our checkbook, or writing blank checks to the VA. It will require thoughtful and major reforms so that we can ensure that in the years ahead the VA is worthy of our veterans.

But today, right now, we have veterans that need healthcare and checks we need to write to pay for that, and we need to make sure that these checks are not returned because we do not have enough money in our account.

Then, and only then, can we start the reform effort so that VA is the model of how we care for those who have sacrificed for us, and honored us with their service.

We have got to work together to ensure we are not giving our veterans a check that will bounce because of insufficient funds.

Failure is not an option!

Thank you and I yield back the balance of my time.

STATEMENT OF HON. SLOAN GIBSON, DEPUTY SECRETARY OF VETERANS AFFAIRS

Good morning Chairman Miller, Ranking Member Brown, and Members of the Committee. Thank you for the opportunity to discuss the Department of Veterans Affairs' (VA's) execution of its Fiscal Year (FY) 2015 budget. I am accompanied today by Dr. James Tuchschmidt, Interim Principal Deputy Under Secretary for Health; Mr. Edward Murray, Acting Assistant Secretary for Management and Interim Chief Financial Officer; and Mr. Gregory Giddens, Principal Executive Director, Office of Acquisitions, Logistics, and Construction.

Caring for our Nation's Veterans, their Survivors, and dependents continues to be the guiding mission of VA. Each year, VA executes our budget to ensure we deliver timely, high quality services and benefits to fulfill this mission. As we emerge from one of the most serious crises the Department has ever experienced, we face continuing challenges to ensure our Veterans receive the timely care they have earned through their service. However, we believe that these challenges are surmountable and will continue to work with Congress to reach resolution and develop plans to move forward in achieving our mission.

IMPROVING ACCESS TO CARE

Before reviewing the challenges to VA's budget this fiscal year, it is essential to understand the context in which VA is executing its resources. In response to unacceptable delays in Veterans receiving medical services, in May 2014, VA launched the Accelerating Access to Care Initiative, which included immediate actions to im-

prove Veterans' access to care. Our strategy has focused on four critical activities: staffing, space, productivity, and VA Care in the Community. While more work remains to be done, real progress has been made. For example:

- In the area of staffing, the Veterans Health Administration (VHA) has increased onboard staff by 12,179 since April 2014, including 1,086 physicians, 2,724 nurses, and 4,671 other select critical occupations. As part of this initiative, VHA has hired over 3,700 medical center staff using the new resources provided in the Veterans Access, Choice, and Accountability Act ("Choice Act").
- In order to create additional space, during the last fiscal year VA activated 80 new leases in VHA, totaling 1.3 million square feet and activated newly owned facilities totaling 420,000 square feet. We have dozens of emergency lease transactions in process to more quickly increase available space for Veteran care. Wherever possible, we are increasing the number of primary care exam rooms per provider in order to allow providers to see more Veterans each day.
- We have extended clinic hours into nights and weekends in order to best use our limited space and enhance convenience for Veterans.

Our efforts to improve access to care have been successful. Nationally, VA completed more than 51.8 million appointments between June 1, 2014 and April 30, 2015. This represents an increase of 2.7 million more appointments completed than during the same time period in FY 2013 or FY 2014. In April 2015, VA completed 97 percent of appointments within 30 days of the clinically indicated or Veteran's preferred date; 93 percent within 14 days; 88 percent within 7 days; and 22 percent on the same day. Not only are more appointments being completed, but Relative Value Units (RVUs), a standard measure of clinical output, have increased 10 percent year over year, twice the increase in providers during the same time, confirming improved productivity.

We are managing to complete these appointments while more Veterans continue to come to VA for their care, even though 81 percent have Medicare, Medicaid, Tricare, or private insurance. While the number of Veterans using VA for care has grown about 2 percent per year, many locations where space, staffing, productivity, and community care enhancements have been emphasized are growing at multiples of that rate. Essentially, as we are improving Veterans' access to care across VA, Veterans are responding and seeking VA care at higher rates. Our workload has increased by 10.5 percent in total, for VA care and Care in the Community combined.

THE VETERANS CHOICE PROGRAM AND PURCHASED CARE REFORM LEGISLATION

The Veterans Choice Program is helping VA to meet some of the demand for Veterans healthcare in the short-term, and VA is thankful for the Choice Act's funding to help us address our access issue. In February 2015, when VA transmitted the 2016 Budget to Congress, we noted that the Choice Act investments provide the authorities, funding, and other tools to enhance services to Veterans in the short-term, while strengthening the underlying VA system to better serve Veterans in the future. We also noted that more resources in certain areas would be required to ensure that the VA system can provide timely, high-quality healthcare into the future.

As we gain more experience with executing the Choice Program, we continue to learn how the program can be improved to better serve Veterans. We appreciate Congress passing legislation regarding the driving distance calculation methodology and the increased flexibility for the Secretary to grant waivers for Veteran eligibility for the Choice Program; we hope Congress will consider the other requests we have made identifying solutions to help operate the Choice Program more effectively.

We are also focused on looking internally at the business rules and processes that govern the Veterans Choice Program. When we step back to revise our own practices and focus on long-term work plans, we are creating more efficient processes that will not only support providing better and timelier care to Veterans, but also provide better business relationships with our VA community care providers.

On May 1, VA sent Congress an Administration legislative proposal entitled the "Department of Veterans Affairs Purchased Healthcare Streamlining and Modernization Act." This bill would make critical improvements to the Department's authorities to use provider agreements for the purchase of VA community medical care—in order to streamline and speed the business process for purchasing care for Veterans when necessary care cannot be purchased through existing contracts or sharing agreements. This proposal would ensure that VA is able to provide local care to Veterans in a timely and responsible manner, while including explicit protections for procurement integrity, provider qualifications, and price reasonableness. We urge your consideration of this bill, which will provide VA the right legal foundation on which to reform its purchased care program— which remains critical for Veterans' access to healthcare.

CARE IN THE COMMUNITY

For years, VA has used various authorities and programs in order to provide care to Veterans more quickly and closer to home. In FY 2014, Veterans completed 55 million appointments inside VA and 16.5 million appointments for Care in the Community. Each month, VA completes over 1 million appointments through doctors and clinics in the community, which represents over 20 percent of total appointments. We have succeeded in providing increased access to care by way of Care in the Community by issuing over 2.9 million authorizations in the last 12 months, which is a 44 percent increase over the same period in the previous year. This increase in authorizations will result in millions of additional episodes of care for Veterans should sufficient resources be available.

This unprecedented increase in Veteran access to care has come at a cost. VHA now expects to spend $10.1 billion in FY 2015 for Care in the Community,[1] an increase of $1.9 billion (24 percent) from the $8.2 billion in FY 2014. Our FY 2015 Medical Services budget includes $7.3 billion for Care in the Community, and VA had expected the Choice Program to finance a surge in demand for Care in the Community.

In the past eight months of implementing the Choice Program, we accomplished a significant amount in a short period of time: we have produced and distributed over 8.5 million Veterans Choice Cards, determined Veterans' eligibility, authorized care, coordinated care and managed utilization, established new provider agreements, processed complex claims, and stood up a call center, all with the goal of providing Veterans with the best possible care-experience, while also meeting our obligations to be good stewards of the Nation's tax dollars. We have also been modifying our referral processes to create efficiencies in the system to ensure Veterans are able to receive care timely. We are proud of what we have accomplished; and Veterans are as well, with more of them coming to VA for their healthcare needs.

Unfortunately, the Choice Program has not fully absorbed the additional Veteran demand for care, both inside and outside of the VA. We have had challenges redirecting the flow of care from Care in the Community to the Choice Program. Part of this is due to the fact that, even prior to passage of the Choice Act, we were leveraging Care in the Community to ensure that Veterans were not experiencing excessive wait times. We understand that some of these challenges are also due to employees not fully understanding how the Choice Program works. We continue our outreach to VA facility leadership to improve employees' understanding of the Choice Program and to address any reluctance our staff may have to send Veteran patients into the community to use the Choice Program. Our staff are more familiar and comfortable with assisting Veterans with existing VA community care programs, many of which are long-standing. We must ensure they are just as adept with the Choice Program as well.

We also recognize that the number and different types of VA community care programs and authorities may be confusing to Veterans, our stakeholders, and our employees. We currently have 7 different programs that we utilize to provide care to Veterans, including:

1. Agreements with the Indian Health Service, Department of Defense, Other Federal Agencies, and Academic Affiliates;
2. Veterans Choice Program;
3. Patient Centered Community Care (PC3);
4. Project ARCH;
5. Other national contracts (such as dialysis);
6. Local contracts and local sharing agreements; and
7. Individual authorizations.

Navigating these programs to determine the best fit for a Veteran may be challenging. Therefore, we are currently working to streamline channels of care, billing practices, and mechanisms for authorizations, with the goal of creating a more unified and integrated approach to community care.

We are making efforts to improve how we are managing our Care in the Community program while continuing to do the right thing for Veterans and provide essential access to care. In order to continue these efforts, we have determined that, at the current rate, expected demand for Care in the Community in FY 2015 will cost approximately an additional $2.5 billion. We are currently taking the following actions to mitigate this need.

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[1] Care in the Community includes all inpatient and outpatient care, as well as community nursing homes, dialysis, and emergency care (Millennium Bill) by providers outside the VA. It also includes CHAMPVA and other dependent programs, State Homes, Project ARCH, and Indian Health Service.

- First, we have issued guidance to our facilities to maximize the use of the Veterans Choice Program by, to the extent possible, directing all eligible care to the Choice Program. We estimate that this could reduce the requirement by $500 million, although this estimate is highly uncertain and depends significantly on Veterans' desires to use the Choice Program instead of waiting for an appointment within VA.
- Second, we have analyzed prior obligations for Care in the Community to determine whether the services provided were eligible for and met all of the requirements of the Choice Program; this analysis revealed approximately $24 million that could retroactively be recorded against the Choice Program.
- Third, we have identified approximately $170 million in Medical Services resources, such as funds for travel and training and other areas deemed less critical than paying non-VA care bills that have been reallocated to the Care in the Community program without adverse consequences to patient care.

In addition, we plan to request a transfer of unobligated funds from the Medical Facilities account to the Medical Services account. This transfer will not have an immediate impact to any VA services provided to Veterans. To ensure Veterans are receiving their requested care, we request flexibility through limited authority to use funds from section 802 of the Choice Act to fund Care in the Community, to the extent these costs exceed our FY 2015 budget.

HEPATITIS C

One example of these evolving Veteran needs can be seen in the recent advancements in the treatment of the Hepatitis C virus (HCV). Studies indicate that when these new treatments are used in combination with existing treatment regimens, there is a higher chance of successful treatment in patients with HCV. VA is a leader in the U.S. in HCV care, including screening, treatment, and prevention. We want to ensure our Veterans are provided with the best treatment options available to them, so we successfully set up an infrastructure capable of ensuring treatment can be provided whenever appropriate. However, in providing this critical care, we are facing a funding shortfall for the cost of HCV treatment.

As you know, the Veterans healthcare Budget Reform and Transparency Act of 2009 (P.L. 111–81) established funding for VA's medical care accounts through an Advance Appropriation (AA). Under this process, VA must estimate funding needs two years in advance of their execution. While the AA provides VA with timely and predictable funding, the process can introduce additional risk of variance between projected and actual costs. The shortfall for HCV treatment is evidence of this risk that can be shown by a timeline of events:

- In the summer 2012, VHA developed the internal budget requirements for its FY 2015 AA request.
- In April 2013, we submitted our FY 2014 budget, which included the FY 2015 AA request for VA Medical Care.
- In summer 2013, VHA developed its internal budget requirements for its FY 2015 revised appropriation request, to be submitted with its FY 2015 budget.
- In November and December 2013, the Food and Drug Administration (FDA) approved two antiviral medications for use as part of combination regimens which offer shorter treatment durations and decreased side effects in addition to increased cure rates, but are more expensive than prior treatments.
- In January 2014, Congress passed the final FY 2014 appropriations bill (Consolidated Appropriations Act, 2014) which did not identify a specific amount of funding designated for HCV treatment as part of the FY 2015 AA.
- In March 2014, we submitted our FY 2015 budget, which included the FY 2015 revised appropriation request for VA Medical Care.
- In April 2014, we added the most recently approved FDA-approved treatments to our formulary.
- In September 2014, we alerted Congress to the impending FY 2015 shortfall in funding for HCV treatment in a "Sufficiency Letter" which provided an evaluation of the sufficiency of the FY 2015 AA request.
- In December 2014, the FDA approved additional HCV drugs that were proven to be more effective in treating HCV than the previous treatments. In December 2014, Congress passed the final FY 2015 appropriations bill (Consolidated and Further Continuing Appropriations Act, 2015) which did not identify a specific amount of funding designated for HCV treatment.

In our September 10, 2014, Sufficiency Letter, VA stated that it had reviewed the capacity and resource requirements to determine if additional funding was required in FY 2015 for known emergent needs. We stated that we had "identified additional resource requirements that cannot be funded through the resources allocated in Public Law 113–146, or within existing resources" and estimated that new drug

treatment for HCV would increase VA's drug costs in FY 2015 by $673 million. The Sufficiency Letter also noted that, due to the timing of the Food and Drug Administration's approval for new HCV medications, the Administration was unable to incorporate their impacts when developing the 2015 President's Budget.

To be clear, VA is committed to ensuring that patients with HCV receive the treatment they need. Therefore, to meet the unfunded need in 2015, VHA reallocated $697 million out of other activities to fund HCV treatments. However, this funding is not sufficient to ensure we are providing the best care to HCV-infected Veterans. We now expect the cost of HCV treatment to be approximately $1.1 billion in 2015. We are currently addressing the $400 million funding shortfall by referring Veterans who need HCV treatment to the Choice Program, but we are concerned that Veterans who would prefer to receive this care within the VA system are not able to do so. In addition, referring HCV-infected Veterans to the Choice Program is not the best model to provide care that meets both Veterans' needs and taxpayers' interests because of the increased costs, complexities, and requirements for coordination of care. It is in our Veterans' interest for VA to provide these life-saving treatments. This is a point where adding flexibility in the use of funds appropriated for the Choice Program could help Veterans receive care in timely fashion. For the reasons discussed above, we would like to continue our discussions with the Committee on this concept.

CONSTRUCTION

VA acknowledges the challenges we have experienced in building the Denver Replacement Medical Center facility in Aurora, Colorado. We are committed to doing what is right for the Veterans in the Colorado Region and completing this major construction project without further delay. VA is dedicated to getting the project back on track in the most effective and cost efficient manner possible.

As I have stated previously, the delays and cost overruns that have plagued the Denver Replacement Medical Center campus are inexcusable. In order to prevent a recurrence of the unacceptable mistakes made on the Denver project, VA is expanding its relationship with the U.S. Army Corps of Engineers (Corps) regarding management of future VA major construction projects. Out of the 15 major construction projects that VA anticipates will be in active construction within the next three years, five are already underway and past the logical transition point for the Corps to take over. VA expects to designate the Corps as our construction agent for seven other projects, which total 86 percent of the value of the 10 active major construction projects. In the future, VA believes that the Corps should be designated as our construction agent for all new medical facilities with a cost of $250 million or greater that have not yet started construction.

In addition, VA has also instituted a number of other specific reforms based on best practices from the private and public sector, including:

- Integrated master planning to ensure that the planned acquisition closes the identified gaps in service and corrects facility deficiencies.
- Requiring major medical construction projects to achieve at least 35 percent design prior to cost and schedule information being published and construction funds requested.
- Implementing a deliberate requirements control process, where major acquisition milestones have been identified to review scope and cost changes based on the approved budget and scope.
- Institutionalizing a Project Review Board (PRB) that is similar to the structure at the Corps District Offices. The PRB regularly provides management with metrics and insight to indicate if/when a project requires executive input or guidance.
- Using a Project Management Plan for accomplishing the acquisition from planning to activation to ensure clear communication throughout the project.
- Establishing a VA Activation Office to ensure the integration of the facility activation into the construction process for timely facility openings.
- Conducting pre-construction reviews wherein major construction projects must undergo a "constructability" review by a private construction management firm to review design and engineering factors that facilitate ease of construction and ensure project value.
- Integrating Medical Equipment Planners into the construction project teams. Each major construction project will employ medical equipment planners on the project team from concept design through activation.

We believe that these reforms will allow us to avoid the mistakes of the past and ensure VA construction projects are executed in a manner that will better serve Veterans and American taxpayers.

BUDGET PROCESS IMPROVEMENTS

We fully recognize that there are areas where VA could have managed our FY 2015 budget more effectively. A continuing challenge is that historically, VA has not operated as an integrated enterprise and relies on old or inadequate enterprise-wide systems. For example, our financial management system is more than 20 years old; we require an integrated logistics system to provide supplies and services on an as-needed basis; and we require an integrated human resources system to fully manage our recruitment, hiring, and staffing processes. VA also does not have a modern medical claims management system for accurate, actionable data on obligations for Care in the Community. VHA relies on staff-intensive transactions to execute its budget for Care in the Community. Manual processes cannot keep pace with the unprecedented surge in demand that VHA is experiencing in FY 2015.

In the future, we are taking a close look at our business practices for the Care in the Community program, with an eye to streamlining and automating processes. We also are pursuing a different approach to better identify resource requirements in the future and tie them to Veteran-centric outcomes.

CLOSING

Veterans are VA's sole reason for existence and our number one priority. In today's challenging fiscal and economic environment, we must be diligent stewards of every dollar and apply them wisely to ensure that Veterans—our clients—receive timely access to the highest quality benefits and services we can provide and which they earned through their sacrifice and service to our Nation. We also acknowledge the responsibility, accountability, and importance of showing measurable returns on that investment. You have my pledge that we will do everything possible to ensure that VA is a responsible steward of taxpayer resources, and that funds appropriated will continue to be used to improve the quality of life for Veterans and the efficiency of our operations. We are proud to be part of this VA team and feel privileged to be here serving Veterans at this key time in history. Thank you for the opportunity to appear before you today and for your steadfast support of Veterans.